Attitudes, beliefs and myths about suicidal behaviour:

A qualitative investigation of South African male students

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I'm the authorship owner thereof and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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B L Meissner Date

ABSTRACT

Suicidal behaviour is a serious public health problem. Globally and in South Africa a gendered pattern of suicide rates has been observed, with males being more likely to kill themselves than females. To date little quantitative and qualitative research is available on young male suicidal behaviour in South Africa. This study investigated the attitudes, beliefs and myths young male students hold about suicidal behaviour. Thirteen male university students (ages 20 to 25 years; with and without a history of suicidal behaviour), who volunteered to take part in the present study in response to an email invitation, were interviewed. The attitudes, beliefs and myths identified from the qualitative data are grouped into four themes: 'Moral acceptability of suicidal behaviour', 'Perceived causes and risk factors of suicidal behaviour', 'Perceived motives of suicidal behaviour', and 'Perceived prevention and protective factors of suicidal behaviour'. Besides these four themes, two underlying narratives are identified and discussed: (1) 'Apart or a part: Belonging and suicidal behaviour' is centred on the idea that perceiving oneself to be an integral part of a social system is protective against suicidal behaviour, while a thwarted sense of belonging increases vulnerability to suicidal behaviour. (2) 'Dying to be a man: (Re) negotiating masculinity and suicidal behaviour' is concerned with participants' views that men's relational position to hegemonic (socially most dominant) forms of masculinity is a factor in male suicidal behaviour. Participants regard hegemonic forms of masculinity to be both a part of the problem of suicidal behaviour and a potential solution to suicidal behaviour. These findings are interpreted through a social constructionist lens of gender as performance. Finally, implications of findings for future research, prevention and treatment are discussed.

Keywords: Suicidal behaviour, attitudes, beliefs, myths, male students

OPSOMMING

Selfmoordgedrag is 'n ernstige openbare gesondheidsprobleem. Wêreldwyd en in Suid-Afrika is mans meer geneig as vrouens om selfmoord te pleeg. Tot op hede is daar min kwantitatiewe en kwalitatiewe navorsing beskikbaar van jong manlike selfmoordgedrag in Suid-Afrika. Hierdie studie ondersoek die houdings, oortuiging en mites oor selfmoordgedrag van jong manlike studente. Dertien manlike universiteitstudente (ouderdomme 20 tot 25 jaar, met en sonder 'n geskiedenis van selfmoordgedrag) het vrywillig aan die huidige studie deel geneem in reaksie op 'n e-pos uitnodiging. Die houdings, oortuiging en mites wat vanaf die kwalitatiewe data geïdentifiseer is, is in vier temas gegroepeer: ‘Morele aanvaarbaarheid van selfmoordgedrag’, ‘Siening van die oorsake en risiko faktore van selfmoordgedrag’, ‘Waargenome motiewe van selfmoordgedrag’, en ‘Waargenome voorkoming en beskermende faktore van selfmoordgedrag’. Naas hierdie vier temas, is twee onderliggende temas geïdentifiseer en bespreek: (1) ‘Samehorigheid en selfmoordgedrag’ is gemoeid met die idee dat om 'n integrale deel van 'n sosiale sisteem te wees is beskermend teen selfmoordgedrag, terwyl ‘n persepsie van isolasie tot selfmoordgedrag kan lei. (2) ‘Onderhandeling van manlikheid en selfmoordgedrag’ is gemoeid met die deelnemers se sienings dat mans se verhouding tot hegemoniese vorme (sosiaal mees dominante vorme) van manlikheid 'n faktor in manlike selfmoordgedrag is. Deelneemers beskou hegemoniese vorme van manlikheid as beide 'n deel van die probleem en 'n moontlike oplossing vir selfmoordgedrag. Hierdie bevindinge is geïnterpreteer deur middel van 'n sosiale konstruksionistiese lens van geslag as prestasie. Die implikasies van die bevindings vir toekomstige navorsing, voorkoming en behandeling word ten slotte bespreek.

Sleutelwoorde: Selfmoordgedrag, houdings, oortuiging, mites, manlike studente

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CHAPTER 1: INTRODUCTION AND MOTIVATION

1.1.Introduction

Suicidal behaviour ranges from suicidal ideation, suicide plans, suicide attempts to death by suicide and is characterised by a desire to die (Ahrens, Linden, Zäske, & Berzewski, 2000). Statistically, suicidal behaviour is a rare occurrence. However, the suicidal behaviour of a person has far-reaching physical, psychological and financial costs. Besides health damaging or lethal consequences for the suicidal individual, suicidal behaviour exacts a toll of grief and suffering on the immediate circle of relatives and friends, which contributes to the high public health care burden in South Africa (Schlebusch, 2005). In the light of these costs, measures are sought to prevent suicidal behaviour or at least lower its incidence.

Before embarking on prevention efforts, however, an understanding of what suicidal behaviour means to a particular target group of people is regarded essential (Colucci, 2006). Hjelmeland and Knizek (2010) observe that currently the largest proportion of published research in the field of suicidology employs a quantitative methodology and focuses predominantly on explaining suicidal behaviour in linear cause-effect terms. Hjelmeland and Knizek (2010) argue that in order to move the study of suicide and suicide prevention forward qualitative research focusing on understanding the meaning(s) that people assign to suicidal behaviour is needed.

One approach of advancing our understanding of suicidal behaviour is to explore the attitudes, beliefs and myths that people hold about the behaviour. According to Hjelmeland and Knizek (2004), suicidal behaviour is an anxiety-provoking and unpleasant subject that people tend to avoid and they therefore develop certain attitudes, beliefs and myths in order to make sense of the behaviour. These attitudes, beliefs and myths may cloud people's sensitivity to signals displayed by suicidal individuals and may act as a barrier to their own help-seeking of informal or professional support (Anderson, Standen & Noon, 2005; Brunero,

Smith, Bates & Fairbrother, 2008). Moreover, several authors propose that the prevailing normative evaluations of suicidal behaviour in a particular socio-cultural context have a strong bearing on the frequency of suicidal behaviour and the way that it is performed (Boldt, 1982; Canetto & Lester, 1998; Canetto & Sakinofsky, 1998). According to Roen, Scourfield and McDermott (2008), "suicide only becomes possible insofar as it is imaginable, insofar as it is meaningful" (p.2089). Studying people's attitudes, beliefs and myths can help to inform us about the meanings that people attribute to suicidal behaviour and how these influence their reaction towards others' or their own suicidal behaviour (Bagley & Ramsay, 1989). Boldt (1988) writes:

> (…) no one who commits suicide does so without reference to the prevailing normative standards and attitudes of the cultural community. Therefore, cause of suicide can be understood only with reference to the socio-cultural norms and attitudes that govern suicide in each cultural community. (p.106)

Only a few recent studies have employed qualitative methodologies to explore how people from at-risk population groups for suicidal behaviour make sense of the behaviour (e.g. Cleary, 2012; Knizek, Kinyanda, Owens, & Hjelmeland, 2011; Niehaus, 2011; Roen et al., 2008). Little is known to date about the meaning that young male students assign to suicidal behaviour, despite this population group being amongst the highest at risk for suicide, both globally and in South Africa (World Health Organisation (WHO), 2007). The aim of the present qualitative study is to gain a better understanding of the attitudes, beliefs and myths that young male students in South Africa hold about suicidal behaviour.

In this chapter key terminology employed throughout the dissertation will be clarified. Thereafter an overview of the epidemiological trends of suicidal behaviour will be provided. This is followed by a description of the motivation and the aims and objectives of the present study.

1. 2. Key terminology

Suicidology is the scientific study of suicidal phenomena (Shneidman, 1981).

Suicidal behaviour or Suicidality is defined as a spectrum of suicidal phenomena, ranging from thoughts of suicide, planning suicide and attempting suicide to death by suicide and is characterised by a desire to die (Ahrens et al., 2000).

Suicide is defined as "an act with fatal outcome, which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes" (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006, p. 12).

Non-fatal suicide or attempted suicide will be used interchangeably to refer to "a nonhabitual act with nonfatal outcome that the individual, expecting to, or taking the risk to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes" (De Leo et al., 2006, p. 14).

Suicide ideation refers to thoughts of harming or killing oneself, irrespective of intent (O'Carroll et al., 1996).

Attitude is defined as the lasting cognitive, emotional and behavioural evaluation of an object or entity, which explains and predicts human behaviour and forms the basis of a person's social construction of the world he/she lives in (Arnautovska & Grad, 2010; Kodaka, Poštuvan, Inagaki, & Yamada, 2010).

A **belief** is regarded as the "subjective probability that an object has a certain attribute" (Ajzen, 2012, p.12), meaning that an individual considers a specific premise to be true, in the absence of evidence supporting it.

Myths are people's way of making sense of a phenomenon that they find difficult to understand otherwise (Lévi-Strauss, 1980).

1.3. Epidemiology of suicidal behaviour

Due to stigma and social taboos surrounding suicidal behaviour, the behaviour is not always given the serious attention it merits (Schlebusch, 2005). What often goes unrecognised is how widely pervasive suicidal behaviour has become (Schlebusch, 2005). Globally, about one million people kill themselves every year (WHO, 2007) and a worldwide rise in suicide rates of up to 60% for the past 45 years has been reported in 2002 (WHO, 2002).

In South Africa the reliability of statistics on suicidal behaviour is clouded by stigma and lack of accurate registration systems (Schlebusch, 2005). However, previous studies and anecdotal data indicate that suicidal behaviour is a significant public health problem in South Africa (Calder, 2004; Schlebusch, 1995). Similar to global figures, suicide in South Africa accounts for about 10% of all non-natural deaths (National Injury Mortality Surveillance System (NIMSS), 2008) and the national prevalence of fatal suicidal behaviour is estimated to lie between 17 and 25 per 100 000 (Schlebusch, 2005).

The rate of nonfatal suicide attempts in South Africa is estimated to be 20 to 40 times higher than fatal attempts, amounting to about 160 000 suicide attempts a year and 440 suicide attempts per day (Schlebusch, 2002). A recent South African study reported that the estimated life time prevalence of suicide ideation, suicide plans and suicide attempts in a nationally representative sample is 9.1%, 3.8%, and 2.9% respectively, which is comparable to that of developed countries (Joe, Stein, Seedat, Herman, & Williams, 2008).

It is unknown how much suicidal behaviour contributes to the health care bill in South Africa. However, considering that the cost for society of each attempted suicide in Sweden, for example, is approximately 50 000 Euro, the need to prevent suicidal behaviour becomes acute (Swedish Rescue Service Agency, 2004, as cited in Skogman, 2006, p.9).

Age. Previously the highest suicide rates were noted in the elderly, but an increase in suicide rates has lately been observed among young populations in a third of countries (WHO, 2002; WHO 2007; see Figure A1 and A2 in Appendix A). A shift in higher suicide rates from the elderly to younger population groups, termed the "ungreying effect", has also been observed in South Africa in recent years (Schlebusch, 2005). While suicide in South Africa is a relatively rare occurrence amongst children and young adolescents between 5 and 14 years of age, it is found to drastically peak between 15 to 24 years of age. Suicide currently ranks as the third leading cause of death after car accidents and homicide in the age group (NIMSS, 2008). The most recent national statistics show that approximately two-thirds of suicide victims are between the ages of 15 to 29 (NIMSS, 2008). Finally, mortuary data of children and youth (age 10-24 years) recorded in the Stellenbosch district between 2001 and 2005 reveal that the average age for all cases of suicide was 19.5 years (Simmons, 2008).

Method. According to NIMSS (2008), hanging is the most frequently used means of suicide with a total of 46.2%, followed by poisonings (17.0%), and firearms (13.5%). Of the total number of hangings, the 15-24 age group ranked as the highest with 54.1%. Hanging is also found by Simmons (2008) to be the most frequent method used by children and youth (age 10-24 years) in the Stellenbosch district.

Gender. Suicidal behaviour has been observed to be gender normative in almost all regions of the world (Canetto & Lester, 1995). While global rates of nonfatal suicide are higher amongst females, males consistently represent the majority of deaths by suicide, except in some regions, such as mainland China (WHO, 2007). Males in South Africa complete suicide four times more often than females, whilst females report twice more suicidal attempts than males (NIMSS, 2008, Schlebusch, 2005). This gender paradox has also been observed amongst adolescents in South Africa in some localised studies (e.g. Simmon, 2008), while others found no gender differences (e.g. Madu & Matla, 2003).

1.4. Motivation for the present study

From a suicide prevention advocacy standpoint, suicide is understood to be a needless tragedy (Mann et al., 2005). Preventing suicidal behaviour has however proved challenging as the current knowledge base on suicide aetiology and epidemiology in South Africa is still lacking (Schlebusch, 2005). For example, no baseline data is available to identify trends of suicides across time (Schlebusch, 1995).

During the last fifty years the field of suicidology made great strides in identifying the role of risk factors in suicide attempts and completion. Yet, risk factors for suicidal behaviour are so numerous that it is difficult to develop effective and relevant suicide prevention programmes (De Leo, 2009). To prevent suicidal behaviour it is important to not only understand the universal risk factors and causes of suicidal behaviour, but also be cognisant of the prevailing attitudes, beliefs and myths surrounding suicidal behaviour (Salander Renberg, Hjelmealnd, &Koposov, 2008), According to Canetto (1997) these attitudes, beliefs and myths determine the form, frequency and social consequences of suicidal behaviour.

The large majority of research on suicidal behaviour in South Africa has been obtained from data from mortality records or hospital patients (Flisher et al., 1992). There is still a lack of knowledge on the prevalent attitudes, beliefs and myths about suicidal behaviour in young populations and males in non-clinical settings (Hjelmeland & Knizek, 2010), despite the fact that two-thirds of suicide victims in South Africa are reported to be male and between the ages of 15 and 29 (NIMSS, 2008). A review of the literature shows that most studies performed on attitudes towards suicidal behaviour (1) focus on third party or public acceptability of suicide (e.g. Li & Phillips, 2010), or on medical, nursing, police and teaching students' views towards suicidal individuals (e.g. Osafo, Knizek, Akotia, & Hjelmeland, 2011b), (2) are conducted in Western countries (particularly the United States and Scandinavian countries), while only a few studies have been undertaken in Africa

(Hjelmeland, Akotia, et al., 2008) and (3) employ quantitative methodologies (Hjelmeland & Knizek, 2010).

Quantitative research is valuable in order to describe patterns of suicidal behaviour and statistical associations with other social and psychological factors, but on its own provides an incomplete understanding of the nature of suicidal behaviour, because it limits the exploration of the socio-ideological context (Hjelmeland & Knizek, 2010). According to Osafo, Knizek et al. (2011b) qualitative research in suicidology is important because it allows us to gain an understanding of "the perceptual experience and meaning/s behind the statistical explanations" (p.3).

Scant research (both qualitative and quantitative) is available on male suicidal behaviour and men's views of suicidal behaviour in South Africa (Niehaus, 2012). According to Canetto and Cleary (2011), a diversity of perceptions and experiences of suicidal behaviour can be found among men. Canetto and Cleary (2011) therefore suggest identifying specific at-risk groups as target groups for research. The present study includes only young male students as participants, since they form part of an at-risk group for suicide in South Africa and can be considered key informants for the attitudes, beliefs and myths about suicidal behaviour that are prevalent in this group. The social and ideological context appears to be different for men and women, according to Kinyanda et al. (2005). By focusing on one gender only in qualitative research more gender-specific ideologies and reasoning may be identified than when undertaking a comparison of men's and women's views of suicidal behaviour (Knizek et al., 2011).

Furthermore, suicide appears to be a particular cause of concern amongst students (Curtis, 2010). Some studies conducted with college populations in the United States report a higher risk for suicidal behaviour among college students, compared to same-age peers that do not attend college (e.g. Hirsch & Barton, 2011). It is argued that being a student is

characterised by an array of experiences, aspects of which may have the potential to become risk factors for suicidal behaviour, such as being separated from one's traditional social support networks, academic pressures, and financial concerns (Curtis, 2010; Konick & Gutierrez, 2005).

A dearth of research is available on suicidal behaviour among the South African university student population. A recent cross-sectional study by Porter, Johnson and Petrillo (2009) examined six priority health behaviours (including tobacco use, alcohol and other drug use, dietary behaviour and physical activity, unintentional injury, intentional injury and sexual behaviours) amongst 635 undergraduate students of a metropolitan University in Pretoria, South Africa. Of the total sample 95.7% were 22 years or younger. The study found that 10% of students had seriously considered suicide during the last 12 months, with 33% of these students reporting to have made specific plans and 20.7% reporting to have attempted suicide. Compared to college student statistics in the United States, suicide ideation rates are similar. However, a higher percentage of South African students engage in planning suicide and attempting suicide.

Taken together, a paucity of research exists in South Africa on young male and tertiary student views on suicidal behaviour, despite suicide rates being high in this population group. By embarking on qualitative research with young male students, the proposed study contributes to addressing this gap in the literature.

1.5. Aims and objectives of the present study

The aim of the present study is to investigate the attitudes, beliefs and myths about suicidal behaviour held by young South African male students, with and without a history of suicidal behaviour. The study is exploratory and the main objective is to gain an insight into the way that male students, who have been identified as an at-risk group for suicide by past

research, make sense of others' and their own engagement in suicidal behaviour. The results of the present study may serve as basis on which future research may be built.

1.6. Outline of the thesis

Following the brief introduction of research on suicidal behaviour above, Chapter 2, 3 and 4 expand on the suicidology literature. Chapter 2 provides a description of the historical and theoretical perspectives on suicidal behaviour, Chapter 3 is a discussion of the role that gender and gender ideologies play with regard to suicidal behaviour and Chapter 4 is a presentation of previous research on attitudes, beliefs and myths with regard to suicidal behaviour.

The literature review (Chapters 2, 3 and 4) is followed by a detailed description of the research design, procedures employed in the present study, researchers' reflection of the research process as well as limitations of the present study in Chapter 5.

The study's findings are split into two Chapters: Chapter 6, which describes and discusses the four main themes identified from the attitudes, beliefs and myths expressed by participants, and Chapter 7, which describes and discusses two core narratives, which traverse the four themes presented in Chapter 6.

In the final chapter, Chapter 8, conclusions are drawn and implications of research findings are considered.

CHAPTER 2: AN HISTORICAL PERSPECTIVE ON ATTITUDES AND BELIEFS ABOUT SUICIDAL BEHAVIOUR

2.1. Introduction

The present chapter provides a broad overview of how attitudes towards suicide have changed over time and how suicide has been understood and explained at different points in history. This historical and theoretical perspective on suicidal behaviour serves as a backdrop to understanding the specific attitudes, beliefs and myths that participants of the present study hold about suicidal behaviour.

2.2. Early civilisations

Attitudes towards suicide can be traced back to ancient Egyptian, pre-Christian Roman and Greek civilisations (O'Connor & Sheehy, 2001).Taking one's life in ancient Egypt was considered a morally acceptable way to die when faced with unbearable suffering (physical or emotional), or civil or religious persecution (Crone, 1996). Pre-Christian Roman and Greek civilisations also viewed suicide as a virtuous act for reasons such as intense grief, shame of dishonour, patriotic principles, and painful and incurable illness (Clarke, 1999). On the other hand, Roman civilization condemned and outlawed suicide for slaves and soldiers, because it deprived slave owners and the state of their human property (O'Connor & Sheehy, 2001).

2.3. The Middle Ages

Stigmatisation of suicidal behaviour reached its height during the middle ages (van Hooff, 2000). During the early years of Christianity suicide through martyrdom was regarded honourable and admirable, because it was believed to be in line with the death of Jesus Christ (O'Connor & Sheehy, 2001). However, the rise in religious mass murders and martyrs posed a problem to the church and led to the sixth commandment "thou shalt not kill" to be interpreted to mean that committing suicide was no different from murdering a family member and that it is a sin against God (O'Connor & Sheehy, 2001). Other religions

propagated a similar view of suicide wrecking havoc in the spirit world (Cvinar, 2005). This led to practices such as funeral rites being denied to those who killed themselves and suicide corpses being mutilated to prevent wandering spirits from being unleashed (Cvinar, 2005; Witte, Smith, & Joiner, 2010). Moreover, family members of individuals who completed or attempted suicide bore the brunt of ostracism, property confiscation and financial penalties imposed on them by communities (Witte et al., 2010).

Furthermore, framing suicidal behaviour as a crime was viewed to deter people from engaging in suicidal behaviour and so measures, such as arresting, publically shaming and (ironically) sentencing suicide attempters to death, were put in place (Cvinar, 2005). Although these measures were considered preventive, they led to suicidal behaviour being highly stigmatised and associated with shame (Van Hooff, 2000).

2.4. Sociological study of suicidal behaviour

In the 18th and 19th century a gradual change in attitudes toward suicidal behaviour occurred. In 1897 the sociologist Emile Durkheim published his best known work, “Le Suicide”, which marked the beginning of modern suicidology (Taylor, 1982). Durkheim (1897/1951) proposed that the characteristics of the social group, rather than individual characteristics, explain why individuals engage in suicidal behaviour (Lester, 1989).

In order to investigate the social nature of suicide, Durkheim (1897/1951) conducted detailed quantitative research on the association between suicide rates and social characteristics (such as age, religion, and marital status) using death records from several countries (Maris, 1997). Durkheim (1897/1951) put forward that the parameters of integration (social relations that attach an individual to other people in a society) and regulation (the moral and normative demands placed on an individual by society) can be used to explain how individuals become susceptible to suicidal behaviour (Bearman, 1991).

Durkheim (1897/1951) proposed that four different types of suicides can be identified on the basis of an individual's integration and regulation: (1) egoistic suicide (suicide as a result of a lack of integration into the society), (2) altruistic suicide (suicide as a result of being overly integrated into a group, to the extent that people sacrifice themselves for the group), (3) anomie suicide (suicide as a result of a lack of regulation by society, such that a person is unable to cope with a crisis in a rational manner), and (4) fatalistic suicide (suicide as a result of excessive control from society, such that a person's identity is limited to being a role occupant in their society). (Berman & Jobs, 1991; Thorlindsson & Bjarnason, 1998)

Numerous scholars have followed and expanded on Durkheim's sociological theory (for example, Henry & Short, 1954), while others challenged it (for example, Douglas, 1967):

Henry and Short (1954) extended Durkheim's theory of anomie suicide by proposing that in the event of external restraints being weak (for example, being socially isolated or having a high social status) and internal restraints being strong (for example, having a punitive superego), people tend to bear the responsibility for the frustration and aggression is directed inwardly as suicide. However, when external restraints are strong (for example, being socially integrated or having a subordinate social status) and internal restraints weak (for example, having a less punitive superego), people tend to blame others for their frustration and aggression is directed outwardly as homicide.

Douglas (1967), on the other hand, criticised Durkheim for using only death records and certificates to draw conclusions about the nature of suicide. Douglas (1967) argued that coroners and medical examiners certify a death as a suicide based on diverse and often unstated criteria, which lead official statistics to be unreliable. Instead of third-person accounts, Douglas (1967) suggested investigating first-person accounts ("situated meanings") of suicide attempters in order to discover what meanings suicidal individuals assign to suicidal behaviour.

2.5. Psychological enquiries into suicide

The 19th and 20th century saw a relief of stigma surrounding suicide as a result of the medicalization of suicide. Sigmund Freud's (1917/1957) work "Mourning and Melancholia" initiated a psychological inquiry into suicidal behaviour. According to Freud (1917/1957), suicide represents an inward turned aggression against an internalised object, which the suicidal individual ambiguously loves and hates, i.e. "murder in the 180th degree" (Shneidman, 1981, p.10). Prior to Freud suicidal behaviour had been explored as a moral, legal, philosophical, spiritual and sociological phenomenon, but not from a medical perspective. Freud (1917/1957) is credited for positioning suicidal behaviour as a matter of clinical interest, which requires treatment instead of moral judgement (O'Connor, 2011). Besides Freud, several other psychodynamic theorists offered interpretations of suicidal behaviour, which are summarised in Table 2.1. below.

Table 2.1.

Summary of psychodynamic theories of suicidal behaviour.

Author	**Basic premise**
Menninger (1938)	Every suicide is characterised by three wishes, of which one is the most predominant: (1) the wish to kill, (2) the wish to be killed and (3) the wish to die.
Wahl (1957)	When frustrating circumstances thwart the development of the individual the libido regresses into the unconscious in order to overcome the frustration and be "reborn" (Pretorius, 1967).
Adler (1958)	The suicidal individual intends to hurt others by inflicting death or injury upon the self (Pretorius, 1967).

Erikson (1968)	The failure of an individual to master the different stages of development across life span predisposes them to suicidal behaviour. Suicide may even become an identity choice for some adolescents when they fail to construct a healthy identity and when overwhelming stress exceeds their ability to cope (Portes, Sandhu & Longwell-Grice, 2002).
Ringel (1974)	The suicidal individual portrays the following characteristics: (1) narrowed perspective and life goals, (2) a constricting circle of friends until being completely isolated (3) suppressed aggression and (4) suicide fantasies, thoughts and communication of intent to others
Buie & Maltberger (1983)	Suicide vulnerability underlies two threats: (1) the threat of loss of the psychological self, which arises from an intense and intolerable experience of aloneness (Aloneness, unlike loneliness, refers to an individual capacity to form memories of soothing and holding from childhood.) and (2) the threat of overwhelming negative self-judgment, which triggers a homicidal rage that is directed against the self as suicide.

Although a number of psychological theories have been proposed since Freud (1917), systematic psychological research on suicidal behaviour has only been conducted about fifty years ago by Edwin Shneidman (O'Connor, 2011). Shneidman (1985) developed an aetiological model of suicide, which states that people are motivated to engage in suicidal behaviour when they experience a combination of maximum "pain" (which is the subjective experience of psychological pain), "perturbation" (general state of emotional upset) and "press" (social or interpersonal pressures and influences that affect the individuals feelings,

thoughts and behaviours). Moreover, Shneidman (1996) identified ten common characteristics of suicides (see Table 2.2.).

Table 2.2.

Shneidman's (1996) ten commonalities of suicide

1. The common purpose of suicide is to seek a solution.
2. The common goal of suicide is cessation of consciousness.
3. The common stimulus in suicide is intolerable psychological pain ("psychache")
4. The common stressor in suicide is frustrated psychological needs.
5. The common emotion in suicide is hopelessness-helplessness.
6. The common cognitive state in suicide is ambivalence.
7. The common perceptual state in suicide is constriction.
8. The common action in suicide is egression.
9. The common interpersonal act in suicide is communication of intention.
10. The common consistency in suicide is with lifelong coping patterns.

Contemporary research is conducted predominantly within the paradigms of social learning, behavioural and cognitive models (O'Connor, 2011). For example, Kral (1994) and Insel and Gould (2008) explain how imitation (or what Phillip's (1974) called the contagion effect) may be involved in suicidal behaviour, whereas Wenzel & Beck (2008) and Rudd (2004) emphasise the role of cognitive errors, distorted thinking and the "cognitive triad" (negative thoughts about self, others, the future) with regard to suicidal behaviour. Hopelessness, problem-solving deficits, and an overgeneral memory style are key cognitive

concepts that have been explored by recent research on suicidal behaviour (Pollock & Williams, 1998; Schotte &Clum, 1987; Wenzel & Beck, 2008; Williams and Pollock, 2001).

2.6. Current perspectives on suicidal behaviour

The shift to more tolerant attitudes towards suicide in the 18th and 19th century has led to decriminalisation of suicide in many parts of the world (except in some countries, such as Ghana and India). Nonetheless, social stigma against suicide survivors and bereaved family members is still widespread today and leads to a lack of openness on the topic. Contributing to the social stigma is the currently prevalent biomedical notion that suicidal behaviour results from a psychiatric disorder. Although the biomedical view is a progressive view of suicide, it is problematic, because it fuels the taboo of suicidal individuals being "mad persons" and thus undignified entities (Marsh, 2011; O'Connor & Sheehy, 2001).

Besides the biomedical model, another dominant model in the suicidology literature is the risk factor model of suicidal behaviour, which distinguishes between proximal (acute) and distal (chronic) risk factors associated with suicidal behaviour (Conner & Ilgen, 2011). Establishing significant risk factors for suicidal behaviour on the individual and population level has been an important focus in the field of suicidology, since it is regarded as a key step for predicting and preventing suicidal behaviour (Vijayakumar, Pirkis, & Whiteford, 2005). Ample risk factors relating to suicidal behaviour have been identified by research. Amongst these risk factors, previous suicide attempts (Moosa, Jeenah, & Vorster, 2005) and mental illness (Harris & Barraclough, 1997, Khasakhala et al., 2011) have been foregrounded as some of the strongest risk factors for suicidal behaviour.

Only in the last decade testable models that integrate psychological, social and biological factors have been proposed. Three of the most prominent theories are: The Cry of Pain theory, Joiner's interpersonal psychological theory, and the Integrative Motivational Volitional model of suicidal behaviour, which will be briefly discussed below.

2.6.1. Cry of Pain. Williams (Williams, 1997, 2001; Williams & Pollock, 2000, 2001) expanded on the escape theory of Baumeister (1990) by proposing that suicide is a reaction to a situation with three characteristics: defeat, no escape and no rescue (O'Connor, 2003). When all these are present in a situation it causes a biologically-mediated "helplessness script" to be activated, which may lead to suicidal behaviour (Williams & Pollock, 2000).

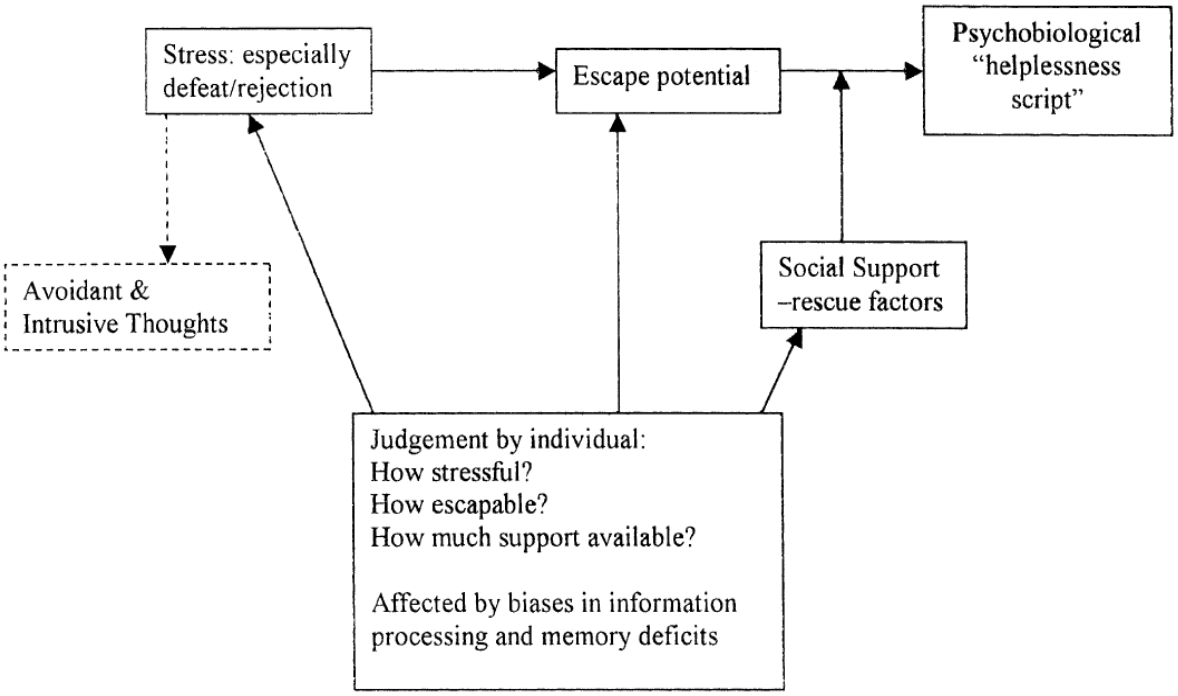

Figure 2.1. Cry of Pain hypothesis. Reprinted from "Suicidal behavior as a cry of pain: Test of a psychological model", by R.C. O'Connor, 2003, *Archives of Suicide Research, 7*, p. 300. Copyright 2003 by the International Academy for Suicide Research.

The theory of Williams and colleagues stems from the observation of "arrested flight", which is exhibited by birds when they are trapped (MacLean, 1990). William and colleagues suggest that a similar reaction occurs in humans. They argue that as with birds, it is not so much the defeat, but the state of entrapment that poses a danger for humans to

engage in suicidal behaviour, because it blocks one's motivation to escape a situation in other ways than by self-destruction. Williams and colleagues thus contend that suicide is not a cry of help, but a cry of pain to a situation that is trapping a defeated individual, with seemingly no escape or rescue.

2.6.2. Joiner's interpersonal psychological theory (see Figure 2.2.) is based on three components, namely (1) thwarted belongingness, (2) perceived burdensomeness, and (3) acquired capability to withstand fear of death and perform lethal self-injury.

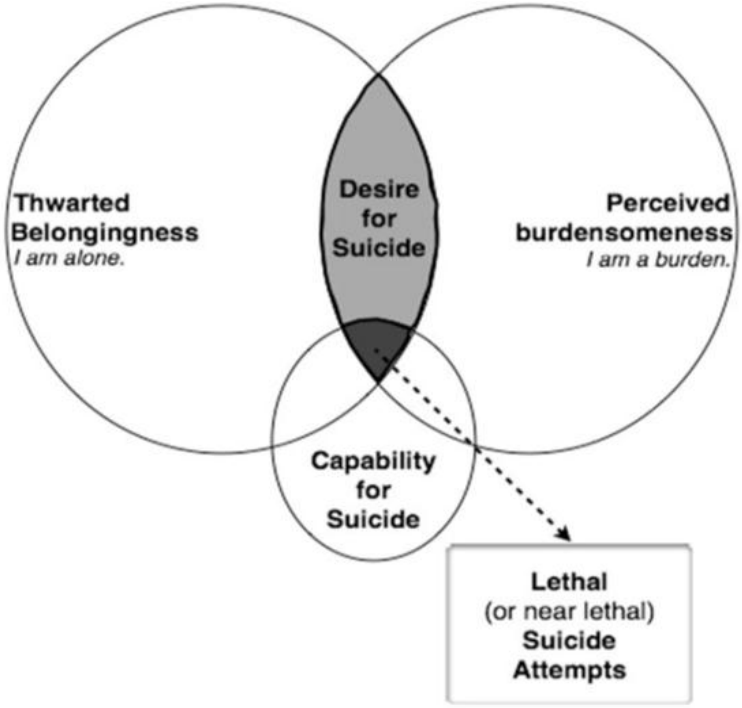

Figure 2.2. Assumptions of the interpersonal psychological theory. Reprinted from "The interpersonal theory of suicidal behavior," by K.A. Van Orden, T.K. Witte, K.C. Cukrowicz, S. Braithwaite, E. A. Selby, and T.E. Joiner, 2010, *Psychological Reviews, 117*(2), p. 42. Copyright 2010 by the National Institutes of Health.

In short, the interpersonal psychological theory states that an individual has a desire to kill themselves when (1) he/she feels disconnected from others and (2) feels that he/she is a

burden to other people (e.g. family, peers and teachers). In addition, the theory states that an at-risk individual will not attempt or commit suicide unless he or she has acquired the ability to lethally injure themselves. This ability is developed over time through being repeatedly exposed to situations that are painful and provocative. (Ribeiro & Joiner, 2009)

2.6.3. The Integrated Motivational-Volitional Model of suicidal behaviour (IMV, O'Connor, 2011, see Figure 2.3.) is a model that conceptualises suicidal behaviour as being determined by a complex interaction of proximal and distal factors. These factors are grouped into three phases: the pre-motivational, motivational and volitional phase.

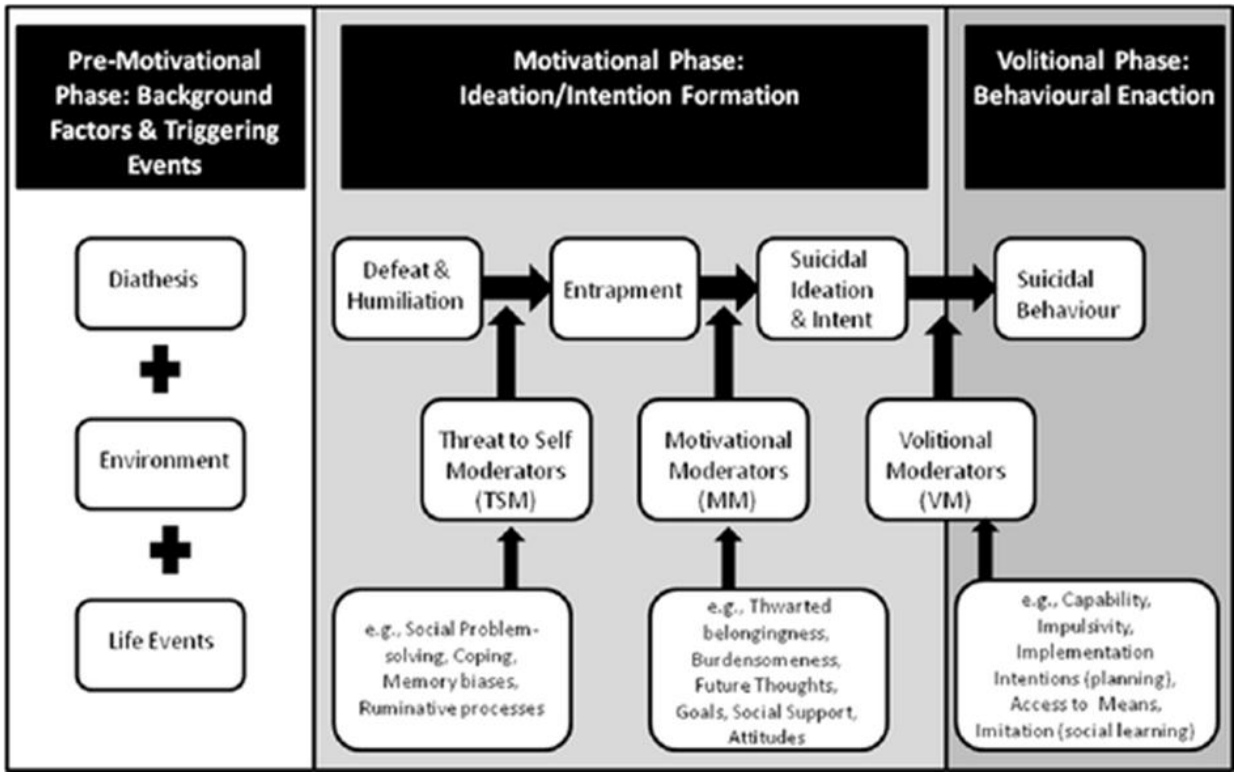

Figure 2.3. The Integrated Motivational-Volitional Model of Suicidal Behaviour. Reprinted from *International handbook of suicide prevention: Research, policy and practice* (p.182), by R. C. O'Connor, S. Platt & J. Gordon (Eds.), 2011, Chichester, England: John Wiley.

The key proximal predictor of suicidal behaviour is proposed to be one's intention to engage in suicidal behaviour - a concept which is borrowed from the Theory of Planned Behaviour (Ajzen, 1991). The IMV describes a person's suicidal intention to result primarily from feelings of entrapment, which are triggered by defeat/humiliation appraisals. Serving as the basis for this proposition is the theory by Williams (2001), which states that situations of arrested flight (feeling defeated and trapped with no rescue) are precursors for suicidal behaviour. The IMV expands on the arrested flight model by stipulating specific moderators that explain the transition from defeat/humiliation to entrapment (called "threat to self moderators"), from entrapment to suicidal ideation/intent (called "motivational moderators"), and from suicidal ideation/intent to suicidal behaviour (called "volitional moderators") (see Figure 2.3 for examples of moderators).

Finally, the model incorporates the principle of vulnerability to stressors from the diathesis-stress model and thereby recognises that suicidal behaviour does not occur in a biosocial vacuum, but that diathesis together with environmental influences and negative life events constitute the pre-motivational phase of suicidal behaviour.

2.7. Conclusion

This chapter outlines the major shifts in attitudes and beliefs about suicidal behaviour across time periods in history and how these influenced the development of theories. Regrettably, there is a lack of knowledge on how suicidal behaviour has been viewed in African countries across time. No theoretical reflections on suicidal behaviour in Africa exist (Knizek et al., 2011). Although suicidal behaviour is a universal human behaviour, it is also a localised phenomenon that has different meanings in different contexts (Colucci, 2006). It thus seems appropriate to explore the views that different groups of people who are at risk for suicidal behaviour have about suicidal behaviour, rather than merely transferring existing theoretical models to such groups.

CHAPTER 3: GENDERED NATURE OF SUICIDAL BEHAVIOUR

3.1. Introduction

Epidemiological data indicates that the rate of completed suicide is higher among young men than among women. This has led some theorists to suggest that male sex, male gender and hegemonic models of masculinity are implicated as a causal factor in completed suicide. This chapter sets out to explore the gendered pattern of suicide, by describing what is meant by gender and thereafter discussing how performing gender may be related to suicidal behaviour.

3.2. Understanding gender

Gender as a concept has undergone a shift from essentialist to constructionist. From an essentialist perspective, gender is seen as the innately-determined manly and womanly characteristics that remain unchanged across cultures and throughout history. This perspective has been influenced by interpretations of the work of Charles Darwin and leaves little room for individual agency, choice and change (Whitehead, 2002).

Another popular psychological theory refers to gender as singular male and female "schemas" or "role containers" (Kimmel, 1986). According to this view, males and females have an inherent need to fulfil appropriate gender stereotypical roles. However, the theory is controversial because it oversimplifies gender as a binary and does not explain what compels men and women to fulfil these roles (Connell, 1995; Courtney, 2000).

In recent decades two key theories emerged that understand gender in more complex terms than the binary constructs of sex/gender and femininity and masculinity: (1) gender as performance and (2) the construction of multiple masculinities. The present study will analyse research findings through the lens of these two theoretical frameworks.

(1) The theory of gender as performance views gender as a social practice that is constantly refined and negotiated through actions and interactions in everyday life. West and

Zimmerman (1987) contributed significantly to the shift from gender as essentialist to gender as a socially negotiated feature through their concept of "doing gender". They write:

> Doing gender involves a complex set of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine 'natures' (West and Zimmerman, 1987, p.126).

West and Zimmerman (1987) reframed gender as something that can only exist in enactment, in 'doing gender' in interaction with others. In order to become masculine an individual has to engage in a dramaturgical task of putting up a convincing manhood act (Schrock & Schwalbe, 2009). This performance is witnessed and judged by an audience. Depending on the individual's performance and the audience's interpretation of the credibility of their performance, the individual's masculine identity is negotiated (West & Zimmerman, 1987). The masculine identity of a person is thus merely a dramatic effect, which produces varied outcomes and reactions in different social and cultural contexts (Goffman, 1959).

Butler (1990) elaborated on the concept of gender as performance by suggesting that gender is constituted by repetitive acts that congeal over time to produce a stable and coherent 'core' gender identity, creating the illusion that sex is the cause of gender. Butler (1993) reworked performativity as "the reiterative and citational practice by which discourse produces the effect it names" (p. 2) and views gender as being repeated through actions that "precede, constrain and exceed the performer" (p. 234). Gender from this perspective is therefore not a choice per se, because one's choosing is conditioned by previous assumptions and norms (Jaworski, 2010b).

(2) Besides gender as performance, another prominent gender theory is the theory of plural and hierarchical arranged masculinities, which was developed by Connell (1995) based on research focusing on masculinities and its construction in different settings. Below the core ideas of the theory are summarised (Connell, 1995, 2000):

1. Multiple masculinities can be found across different periods of history, different cultures, and even within a single culture, because masculinity is not a fixed individual characteristic of men, but it is socially constructed (Martin, 2003).
2. Masculinities do not exist side by side. Rather, they relate to each other in terms of hierarchies. The most dominant form of masculinity is referred to as "hegemonic", which refers to "things done" by males individually and collectively that function to subordinate feminities and 'other' masculinities which are formed in response to hegemonic masculinity (Schrock & Schwalbe, 2009). Hegemonic masculinity is synonymous with power, authority and resources. Other masculinities rank lower than the hegemonic masculinity. Although many men strive to align themselves with the hegemonic masculinity in their actions and interactions, hegemonic masculinity is usually not the most common form of masculinity because men often do not have the social power to attain hegemonic masculinity (Courtney, 2000). Also, once having attained hegemonic masculinity it is difficult to maintain, since manhood needs to be proved continuously (Evans, Frank, Oliffe, & Gregory, 2011).
3. Masculinities can be collectively enacted not only by individuals, but also by groups and institutions through a shared culture.
4. Body appearances, experiences, pleasures and vulnerabilities are an important way to express masculinities, although they do not define masculinities per se.
5. Masculinities result from what people do, rather than what people are, which links in with West and Zimmerman's (1987) concept that gender should be understood as a verb, rather than a noun.
6. Divisions occur even within masculinities, for example men may be conflicted about being career driven and at the same time being a family man with a desire for emotional connection.

7. Masculinities are dynamic. They are actively constructed and can similarly be reconstructed, contested and displaced, depending on the gender dynamics and tensions in a given society or culture.

In summary, the theories of performativity and multiple masculinities facilitate an understanding of gender as dynamic, enacted and diverse. However, most past research on gender and suicidal behaviour employ a macro-level quantitative approach, which treats gender as descriptive rather than a causal factor in suicidal behaviour, or divides men and women along binary and opposing notions of masculinity and femininity (Cleary, 2012; Payne et al., 2008). This has begun to change recently with the use of qualitative approaches (e.g. Cleary, 2012; Cleary, 2005; Roen et al.,2008, Scourfield, Jacob, Smalley, Prior, & Greenland, 2007), which take into account how the different ways in which masculinity is expressed may be implicated in suicidal behaviour.

3.3. Gender and suicidal behaviour

Hegemonic masculinity is an ideal of manhood, which is never attained or chosen to be entirely attained by most men (Connell & Messerschmidt, 2005). Nevertheless, men tend to aspire to or compare themselves against this ideal (Connell, 2000). According to Connell & Messerschmidt (2005), the pursuit of hegemonic masculinity may be linked to "toxic practices", such as competiveness, aggression and violence. "Doing masculinity" is also proposed to put men at higher risk for suicidal behaviour than women "doing femininity" (Payne et al., 2008). Möller-Leimkühler (2003) posits that masculinity is an important factor influencing how suicidal behaviour is understood, contemplated and enacted by men and deserves more attention in the suicidology literature. What follows below is a discussion of previous research findings and theoretical ideas on how gender may be entwined with suicidal behaviour:

3.3.1. Method of choice. One reason for the notably higher male suicide rates has been linked to male's choice of more lethal and aggressive methods as well as greater accessibility to and familiarity with firearms (Canetto & Cleary, 2011).

Using data from a psychological autopsy study, Denning, Conwell, King and Cox (2000) found that women had a significantly lower likelihood than men to use a violent method, even after adjusting for the following variables: intention to die, presence of a psychiatric disorder, substance abuse and sociodemographic variables. Moreover, research has consistently shown that women are more likely to engage in self-poisoning, whereas men use more lethal methods, such as shooting and hanging (Langhinrichsen-Rohling, Friend & Powell, 2009). One reason why men use more lethal means of suicide is that men are more likely than women to possess, store and use firearms, which may influence them to use firearms instead of less lethal means of suicide (Denning et al., 2000).

Differences in choice of method can also be understood from a gendered perspective. Men's higher likelihood of using more violent or lethal actions is congruent with dominant constructions of masculinity that advocate strength and aggression (Payne et al., 2008). On the contrary, females higher likelihood of using less violent methods (such as self-poisoning) may be linked to the feminine notion of preserving attractiveness and seeking to protect others (Payne et al., 2008). Furthermore, surviving a suicide attempt is seen as more inappropriate for men because it is equated with failure, weakness, femininity and attention-seeking (Canetto, 1997). In contrast, death by suicide is viewed as more acceptable for men than for women because it is in alignment with masculine notions of physical prowess and strength (Canetto, 1997).

3.3.2. Help-seeking and coping behaviours. Females are socialised to seek help for socio-emotional problems and are therefore more likely to receive appropriate treatment, which may prevent them from engaging in or completing the suicidal act (Courtenay, 2000).

Men, in contrast, have a tendency to keep emotional problems to themselves, even in the face of potential suicide, because seeking help is perceived as a signal of vulnerability or femininity, which attracts stigma from other men (Addis & Mahalik, 2003). Men are expected to "sort out their own problems" (Courtenay, 2000) and thus tend to engage in normative masculine behaviours, such as aggression and alcohol or substance misuse, to uphold their masculine identities (Möller-Leimkühler, 2003). Alcohol and substance abuse have been found to occur more frequently prior to suicide among men than among women (Groves & Sher, 2005). While men report using alcohol to numb emotional pain (Brownhill, William, Barclay, & Schmied, 2005), it may paradoxically exacerbate depression and lower inhibitions to engage in suicidal behaviour (Canettoo, 1991).

3.3.3. Social support. Protective factors, like religion, motherhood, social and family support, are more accessible to females than to males (Courtenay, 2000). This may be rooted in the different ways that men and women initiate and maintain social relationships. Men who strongly endorse attributes of hegemonic masculinity, such as independence and control, are found to be less likely to have large and supportive social networks, making them more vulnerable to social isolation, which is a pertinent risk factor for suicidal behaviour (Swami, Stanistreet, & Payne et al., 2008).

Marriage acts as a protective factor against suicidal behaviour for men when it provides for the needed emotional support and stability (Payne et al., 2008). Women are found to compensate for their male partners disregard for seeking help by being concerned about their wellbeing and nurturing them (Oliffe, Kelly, Bottorff, Johnson, & Wong, 2011). However, if marriage breaks down or if the spouse dies, men are more vulnerable to suicide because of their lower social connectedness and capacity for relationships compared to women (Swami et al., 2008). Separated, widowed, or divorced men have been consistently found to have a higher risk for suicide than women counterparts (Luoma & Pearson, 2002).

Not only does divorce trigger depression by detaching men from their primary relationship(s), but it also dislocates them from their protector and provider roles (Oliffe, Orgrodniczuk, Bottorff, Johnson & Hoyak, 2012).

3.3.4. Depression and suicidal behaviour. Major depression is found to underlie more than half of all suicides (Möller-Leimkühler, 2003). Yet, while depression is about twice as common among women than among men, men are about four times more likely than women to complete suicide (WHO, 2007). Payne et al. (2008) suggests that this gender paradox may be an artefact of men's reluctance to seek help for emotional problems or may be due to men expressing depression differently. Several authors propose that men's reaction to depression is influenced by their alignment to masculine norms (Emslie, Ridge, Ziebald, & Hunt, 2006; Langheinrichsen-Rohling, Sanders, Crane, & Manson, 1998; Oliffe et al., 2012). Langheinrichsen-Rohling et al. (1998) found that even though female adolescents reported more symptoms of depression, male and female adolescents did not differ on scores of hopelessness. The authors suggest that females have a tendency for depressive symptoms because it is more acceptable for females to express their discontent. Males, on the other hand, are thought to be more likely to engage in impulsive and risky behaviours because they are socialised to assert independence and physical prowess.

Within a frame of hegemonic masculinity depression is seen as an "unmasculine ailment" and a "woman's disease" by men (Oliffe et al., 2012, p.507). Instead of seeking help men thus resort to self-monitoring their distress with 'coping' behaviours, such as alcohol abuse, in the belief that it will help them to re-establish control (Emslie et al., 2006). Briefly put, men who experience depression are found to exhibit certain emotions (such as anger, anxiety, aggression) and norm-congruent behaviours (such as substance abuse, risk taking behaviours, and over-involvement in work and sports) (Addis & Mahalik, 2003), which may put them at higher risk for engaging in suicidal behaviour than women (Payne et al., 2008).

3.3.5. Development of suicidal behaviour. An emergent body of qualitative knowledge lays emphasises on the process by which men come to engage in self-harming and suicidal behaviour. A qualitative study with a cohort of 38 Canadian men (ages 24-50 years), 13 of which self- identified and 25 were formally diagnosed with depression, found that participants reconcile their despair of severe depression and suicidal ideation by following one of two pathways: (1) Countering suicide by falling back on established connections with friends and family (e.g. masculine protector and provider roles), and/or on religion and morality, in order to dislocate depression from self-harm; or (2) contemplating escape through emotionally-numbing alcohol and/or drug use and/or risky practices of self-harm. (Oliffe et al., 2012)

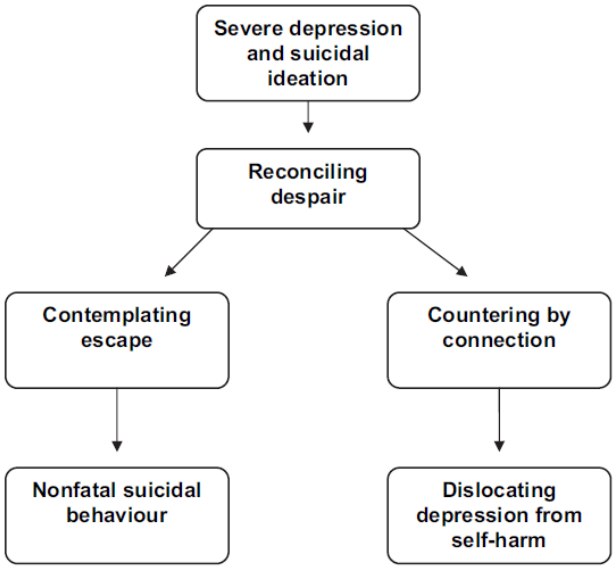

Figure 3.1. Conceptual model of men contemplating or countering suicide. Reprinted from "'You feel like you can't live anymore': Suicide from the perspectives of Canadian men who experience depression", by J.L. Oliffe, J.S. Ogrodniczuk, J.L. Bottorff, J.L. Johnson, and K. Hoyak, 2010, *Social Science & Medicine, 74* (4), p.509. Copyright 2010 by Elsevier Ltd.

Moreover, an Australian grounded-theory study conducted with 77 male teachers and students on their experiences of being "down in the dumps" reported that "acting in" (through avoiding or distancing oneself from problems and through emotional numbing with alcohol and drugs) may lead to a build-up of negative emotions that result in men to "act out" through engaging in risk taking, violence, aggression, crime, or in non-fatal and fatal suicidal behaviour (which is referred to as "stepping over the line") (Brownhill et al., 2005).

Recently, a study by Cleary (2012) with 52 Irish men (age 18-30) with a history of suicide attempts found that while men experienced high levels of distress, they found it difficult to detect symptoms and communicate their distress to others. Moreover, they used coping mechanisms, such as excessive use of alcohol and drugs, which only worsened and prolonged their distress. Accumulation of distress over time was found to result in men seeing suicide as the only way out. Cleary (2012) concludes that alignment with hegemonic masculinity norms, such as resisting emotional disclosure and engaging in maladaptive coping behaviours rather than seeking help, influence men to consider suicide as a viable option.

Finally, Niehaus (2012) conducted an ethnographic study by drawing on narratives of 52 cases of completed suicide in Bushbuckridge in the South African Lowveld. Niehaus (2012) suggests that the gender paradox in suicidal behaviour can be understood in terms of the concepts of "symbolic violence" and "masculine domination" proposed by Pierre Bourdieu (2001). From his observations he concludes that escape from a thwarted dominant masculine position is the main precursor for male suicides, while female suicides represent an act of protest against the consequences of being dominated by men. He also found that men's suicides centred on the performance of autonomy and authority as well as blame directed at themselves for their failures, whereas women's' suicides are centred on social relationships and blame directed at others for their unhappiness.

3.3.6. Sexuality and suicidal behaviour. Since the hegemonic masculinity is perceived as the dominant and natural masculinity, a divergent or subordinated masculinity, including being gay, bisexual or transgender, may represent a risk for suicide (Silenzio et al., 2007). In population studies in North America and New Zealand it was found that suicide attempt rates for lesbian, gay, bisexual and transsexual participants were at least four times higher than suicide attempt rates of heterosexual participants (Bagley & Tremblay, 2000). Specifically gay and bisexual males have been found to be at elevated risk of suicide (Remafedi, French, Story, Resnick, & Blum, 1998). Being lesbian, gay, bisexual and transgender may increase vulnerability to suicide because it is associated with a number of factors that increase psychological distress, such as non-disclosure of sexual orientation to others, 'coming out' and being faced by negative reactions of family and peers, and ostracism from social groups, such as the church community (Gilchrist & Sullivan, 2006; McDermont, Roen, & Scourfield, 2008). All these factors share a common component: isolation, which is a key risk factor for suicidal behaviour (Smalley, Scourfield, & Greenland, 2005).

3.4. Conclusion

This chapter shows that despite prominent gender differences in suicidal behaviour, the vast majority of research treats women and men as distinct and homogenous categories. Only more recently, the gendered nature of suicidal behaviour has been investigated qualitatively and the findings indicate that theories of gender as performance and gender relations holds the potential to inform us about previously unexplored areas of male suicidal behaviour.

CHAPTER 4: ATTITUDES, BELIEFS AND MYTHS ABOUT SUICIDAL BEHAVIOUR

4.1. Introduction

When setting out to understand suicidal behaviour, it is important to examine the meanings that the different groups of people attribute to the behaviour (Boldt, 1982). One way to understand the meaning that people assign to suicidal behaviour is to study their attitudes towards the behaviour. This is valuable, according to Fairbairn (2006), since "the ways that we think about (and act in relation to) the self-harm that an individual causes himself will depend both upon the act that we take it to represent, and our view of such acts" (p.7).

This chapter aims to review the present literature on attitudes towards suicidal behaviour. First, the relationship between attitudes towards suicide and suicidal behaviour is discussed. This is followed by a description of the main correlates of attitudes towards suicidal behaviour. Finally, an evaluation of the current state of research, including cross-cultural applicability, methodological limitations and currently available research in the African context is presented.

4.2. Relationship between attitudes towards suicide and suicidal behaviour

Early research on attitudes in the field of suicidology hypothesized that suicidal behaviour is directly related to the different dimensions of attitudes towards suicide, such as attitudes of predictability, preventability and social acceptability of suicide. Bayet (1922) was one of the first to propose a relationship between attitudes towards suicide and suicide rates (Salander Renberg et al., 2008). Bayet (1922) defined attitudes towards suicide from two viewpoints: morale simple, which refers to condemning suicide, regardless of the precipitating circumstances, and morale noncee, which refers to accepting suicide under specific conditions, while not approving of suicide per se (Arnautovska & Grad, 2010; Jukkala & Mäkinen, 2011). Bayet (1922) found that among people departing from a morale

noncee viewpoint higher suicide rates are observed than among people with a morale simple stance towards suicide, and suggested that there is a positive relationship between suicide rates and suicide acceptability (Salander Renberg et al., 2008).

In the past century numerous studies have been conducted to examine the association between suicide rates and suicide acceptability (see Agnew, 1998 for a review). At present the view of a direct relationship has been replaced by an understanding of more complex interactions between attitudes and suicidal behaviour, based on a number of studies that show that permissive attitudes toward suicide may increase or decrease the rate of suicide. Overall, most of the recent studies on suicidal behaviour report a negative relationship between rates of suicide and permissiveness. For example, a two wave postal questionnaire study (conducted in 1986 and 1996) by Salander Renberg and Jacobsson (2003) in Sweden using the Attitude Towards suicide Questionaire (ATTS) found that suicide rates decreased from 1981 to 1996, with attitudes towards suicide becoming progressively more permissive. However, on an individual level persons with suicidal behaviour were found to hold more accepting attitudes towards suicide than non-suicidal persons (Salander Renberg & Jacobsson, 2003).

The stigma hypothesis explains these contrasting findings in the literature by distinguishing between general attitudes towards suicide and attitudes towards suicidal individuals specifically (Eskin, 1995). According to the hypothesis, if general attitudes towards suicide are stigmatizing in a social context, then individuals engaging in suicidal behaviour are more likely to face social rejection and do not seek help (Eskin et al., 2011). On the other hand, if attitudes towards suicide in general are permissive and liberal, then an individual may consider the idea of killing themselves and engage in suicidal behaviour (Eskin et al., 2011).

It is worthy to note that although countries with social, religious or legal barriers to suicide generally have low suicide rates, these countries often have higher suicide rates than are registered (Tomlinson, 2007). High missing or misclassified rates of deaths in many such countries indicate that suicides may be concealed by family members for social or material reasons (McIntosh, 2002). This affects the accuracy of the results obtained from correlational analysis with attitudes towards suicide and underscores the important role that social and cultural processes may play in the public acknowledgment of suicides (Tomlinson, 2007). Salander Renberg et al. (2008) therefore warn to take caution when drawing conclusions on the direction of the association between attitudes towards suicide and suicidal behaviour on a societal level.

On the individual level, most studies have found a positive association between own permissive attitudes towards suicide and suicidal behaviour (e.g. Eskin, Voracek, & Stieger, 2011, Jukkala & Mäkinen, 2011), although some studies did report contrary findings (Ramsey & Bagley, 1985). On grounds of these conflicting findings the direction of the relationship between suicide and suicidal attitudes is merely tentative. A study by Gibb, Andover and Beach (2006) suggests that attitudes may act as a moderating variable between hopelessness and depression symptoms, and suicidal ideation in men. However, these results remain to be confirmed in a more representative population sample.

To better understand the complexity of the relationship towards suicide and suicidal behaviour (including exposure to and own suicidal behaviour), Salander Renberg et al. (2008) built gender and country-specific models using structural equation modelling. In their model construction they included the attitude dimensions of acceptance, condemnation and preventability of suicide, as well as age and education level. The study found that not only the rate of suicide, but also the attitudes and associated behaviours are patterned by culture and gender. These results indicate that attitudes and the different problem-solving and coping

behaviours these inculcate are important to take heed of when designing gender and culture-specific interventions. Another notable finding of the study is that attitudes towards suicide, and not just previous exposure to a family suicide, may act as a mediating-modulating factor in the familial transmission phenomenon of suicidal behaviour.

Finally, a study by McAuliffe, Corcoran, Keely and Perry (2003) investigated the prevalence of lifetime suicide ideation and its relationship with attitudes towards suicide and problem-solving skills in a sample of 328 university students in Ireland. Lifetime suicidal ideation was identified in a third of students and was significantly associated with poorer problem-solving abilities. With regard to attitudes towards suicide, suicide ideators were more likely than non-ideators to view that suicidal behaviour as normal and view people to have the right to die. Although males and females had similar attitudes towards suicide, males were found to be more in agreement with the attitude that suicide lacks real intent and indicated that they would deny suicidal concerns of a friend, putting it off as a joke.

4.3. Correlates of attitudes towards suicide

Evidence suggests that variation in suicide prevalence rates across different geographical locations, societies and time cannot be adequately explained by changes in rates of psychopathology or other common risk factors for suicidal behaviour, such as differences in living conditions and experiences of adversity (Canetto & Lester, 1995; Neeleman & Lewis, 1999). Recently there has therefore been increased interest in the role that attitudes and beliefs about suicide may play in explaining these differential rates and how these attitudes and beliefs may mediate the relationship between suicidal behaviour and risk/protective factors, such as gender, age, and religion, amongst others.

4.3.1. Religiosity. It has been shown that people with a strong religious upbringing are less likely to see suicide as an option (Domino, 2005; Eshun, 2003; Osafo, Knizek, Akotia, & Hjelmeland, 2011a; Lester & Akande, 1997). There may be several reasons for this

association: (1) Religions provides a moral code of conduct that influences people's attitudes towards suicidal behaviour, (2) religious practices, such as prayer and attending religious meetings, may increase the coping capacity of an individual., and (3) religion may satisfy the need of being cared for by others and God (as an archetype of a carer) (Osafo, Knizek et al.., 2011a).

Despite being more intolerant towards suicide, religious people are nonetheless found to be more supportive of suicide prevention than non-suicidal individuals and thus more willing to help people experiencing suicidality (Osafo, Knizek et al., 2011a).

4.3.2. Age. The increase in youth suicides over past half century has been proposed to be related to more accepting attitudes towards suicide and death (Arnautovska & Grad, 2010; Bagley & Ramsay, 1989; Boldt, 1983).Previous research on attitudes towards suicide shows that unlike older generations, younger generations do not view suicide in moral-religious terms, but in terms of individual rights (Curtis, 2010). Zemaitiene and Zaborskis (2005) found that adolescents with a positive attitude towards suicide as a human right had attempted suicide twice as often than adolescents with a negative attitude. This is in line with Mayekiso's (1995) finding that while secondary school pupils in Umtata, South Africa, generally disapproved of suicide as an option, more than a third of pupils reported it as acceptable under certain circumstances, such as parent death, divorce and loss of contact with parents, chronic physical illness, unresolved problems and love-relationship problems. While some studies on the relationship of age and suicidal behaviour have found more permissive attitudes among younger than older people (Miller, Segal, & Coolidge, 2001), others demonstrate the opposite (Segal, Mincic, Coolidge, & O'Riley, 2004). It thus remains to be shown whether age differences in attitude are due to generational differences (Arnautovska & Grad, 2010).

4.3.3. Gender. With regard to gender, women are found to be generally less accepting of suicidal behaviour than men (Dahlen & Canetto, 2002, Mueller & Waas, 2002). Dahlen and Canetto (2002) report that men were more likely to view suicide as an individual right and that men displayed greater agreement and acceptance with the suicidal decision of a person, regardless of the precipitating factor. Moreover, Linehan (1973) investigated gender differences in attitudes towards suicidal behaviour. Participants evaluated men and women who completed suicide to be more masculine and powerful than men and women who survived a suicide attempt. Men who survived an attempt were also more stigmatised than women. This stigma is reasoned to influence men to choose more lethal means of killing themselves than women. The proposed study sets out to shed more light on young male students understanding of suicidal behaviour and what explanations they offer for the phenomenon.

4.4. Current state of research on attitudes, beliefs and myths about suicidal behaviour

4.4.1. Cross-cultural applicability of research. The currently available research on attitudes towards suicide is limited since it is predominantly conducted in high-income countries, meaning that its relevance in low- and middle-income countries is questionable (Li & Phillips, 2010). Differences in socio-demographic, religious and other factors between the South African population and European populations may well translate into different findings in quantitative attitudinal research about suicide. For example, Hjelmeland, Kinyanda, Knizek, Owens, Nordvik and Svarva (2006) set out to investigate the cross-applicability of the Attitudes Towards Suicide Questionnaire (ATTS) by Salender Renberg and Jacosson (2001, 2003) in a sample of students from Norway and Uganda. They found different factor structures for samples from Norway and Uganda after exploratory and confirmatory factor analysis, and posit that this finding is possibly due to different meanings of suicide in the two countries, which influences responses and latent variables. While the ATTS offers valuable

data on suicide attitudes, Salander Renberg and Jacobsson (2003) emphasise that more needs to be done to determine the applicability of the instrument in different contexts.

4.4.2. Methodological limitations. A large proportion of studies on attitudes towards suicide are quantitative, many of which are conducted by Domino and colleagues employing the Suicide Opinion Questionnaire (SOQ) (Colluci & Martin, 2007). These studies compare the attitudes towards suicide between students of different countries (Domino & Groth, 1997; Lester & Akande, 1994; Lester & Icli, 1990). Lester and Akande (1998) compared attitudes towards suicide between Nigerian and Zamibian students and found that Nigerian students were more in agreement with the attitude that suicide is the result of a mental illness and represents a cry for help than Zamibian students. Zambian students, in contrast viewed suicide as more acceptable and normal than Nigerian students, agreeing more with the attitudes that suicide has clear motives, is rooted in family dynamics and is more lethal. Using the SOQ, Eshun (2003) also found that Ghanaian students, compared to American students, have significantly more negative attitudes toward suicide. Eshun (2003) suggest that qualitative methodologies should be employed in future research in order to gain a deeper understanding of these results.

A need for qualitative studies or mixed method approaches in the investigation of attitudes towards suicidal behaviour has been emphasised by Hjelmeland and Knizek (2010). The authors posit that these methodologies will advance the understanding and not only the explanation of suicidal behaviour.

Using a combined qualitative and quantitative approach in a postal questionnaire sent out to a randomly selected sample of 1000 Norwegians, Hjelmeland and Knizek (2004) examined the prevalence of common myths, views on suicide in general, causes of suicide, prevention of suicide and participants' evaluation of their participation in a study on suicide. In brief, the study found that common myths are still prevalent and that participants assign

intrapersonal causes rather than interpersonal and extra personal causes to suicidal behaviour. It was also found that participants believe that suicide can be prevented.

More recently, Knizek et al. (2011) investigated Ugandan men's view of suicide and suicide prevention, including a religious perspective. Overall, participants had negative attitudes towards suicide, but the majority believed that suicide could be prevented through health care services (45%) and education (22%). Most men perceived suicide to be a reaction to illness (26%) and relationship problems (24%), while other causes of death, including perceived pressure (10%), lack of control (9%) and economic hardship (8%), were less frequently believed to lead to suicide.

4.4.3. Research in the African context. Research on the meaning of suicide in the African context is still relatively scarce (Adinkrah, 2010), although a few studies have been conducted recently, including in Ghana (Osafo, Hjelmeland, Akotia, & Knizek, 2011a), South Africa (Holtman, Shelmerdine, & Flisher, 2011; Laubscher, 2003), Uganda (Knizek et al., 2011) and Tanzania (Ndosi, Mbonde, & Lyamuya, 2004).

In African studies a predominantly negative attitude towards suicide is reported, with religious beliefs and cultural values being found to be the key determinants of attitudes towards suicide (Eshun, 2003; Hjelmeland, Akotia et al., 2008; Osafo, Hjemeland et al., 2011 a, b; Peltzer, Cherian, & Cherian, 1998). Religion plays a protective role by providing its members with beliefs and social resources, which help to increase their feelings of optimism about their futures (Osafo, Knizek et al., 2011a). Negative cultural attitudes towards suicide may serve as a protective factor, although Platt (1989) argues that intolerant and hostile attitudes may also prompt individuals to engage in overt acts such as suicidal behaviour in order to get a desirable response from others.

A number of studies on attitudes towards suicide were conducted in Ghana, a country in which suicide is still legally criminalised and is considered an immoral and condemnable

act from a religious and a social perspective. In a qualitative study, conducted with 27 lay people from urban and rural areas in Ghana, it was found that suicidal behaviour was conceived as a social injury, because it defies the central social value of interconnectedness and speaks to the failed responsibility of the suicidal individuals to share their distress with others (Osafo, Hjelmeland, Akotia, & Knizek, 2011b). Beyond stigmatisation of the suicidal person, families bear the brunt of enduring stigma from community members, because a suicide in the family is viewed to taint their honourable social image. This ideology was found to be one of the key factors influencing the negative attitudes towards suicide held by psychology students in Ghana (Osafo, Hjelmeland et al., 2011b). In another study Adinkrah (2011) set out to understand why men in Ghana, despite strong moral and legal condemnations against suicide, engage in suicidal behaviour. He investigated police data in Ghana from 2006 to 2008 and found that the foremost reason for men, especially young and poor men, to engage in suicidal behaviour was to escape public shame and dishonour.

In South Africa, Mayekiso (2010) investigated attitudes towards suicide among 100 black secondary students in Umtata with a questionnaire constructed by the researcher with no prior pilot study conducted. The study found an overall strong negative attitude towards suicide in the sample. The participants indicated that interpersonal conflict and loss of a significant other could precipitate suicide, but that the concern about the impact of suicide on the family is an important barrier to suicide.

In another study South African study conducted with adolescents (aged 17 to 24 years) in a secondary school in South Africa using the Multi-Attitude Suicide Tendency Scale for Adolescents (MAST-12) found that suicide attempters, compared to non-suicide attempters, had significantly higher scores on the subscales Attraction to Death ($p < .0001$) and Repulsion by Life ($p < .01$) and significantly lower scores on the subscales Attraction to Life ($p < .001$) and Repulsion by Death ($p < .05$) (Peltzer, Cherian & Cherian, 2000). Asians

had the highest suicide attempts (13.5%) followed by Whites (13%) and lastly Blacks with 11.3% (Peltzer, Cherian & Cherian, 2000).

4.5. Conclusion

Research on attitudes, beliefs and myths presented in this chapter indicates that suicidal behaviour reflects wider social, cultural, religious and political influences and tensions. Mäkinen and Wassermann (2001) aptly put it: “Even if a suicide is the result of an individual decision, it neither originates nor is committed in a vacuum” (p.11). In order to understand suicidal behaviour as the complex and multidimensional behaviour that it is, it is crucial to take heed of the local perspectives of suicidal behaviour that influence the attitudes, beliefs and myths young men hold about the behaviour.

CHAPTER 5: METHODOLOGY

5.1. Introduction

As mentioned in the introduction, the current study aims to investigate the attitudes, beliefs and myths that young male students hold about suicidal behaviour. The present chapter sets out to provide an overview of the research design employed by the present study. This is followed by a detailed description of the participant recruitment process, participant characteristics as well as data collection and analysis methods employed. Furthermore, relevant ethical considerations and researcher's comments on the research process are presented.

5.2. Research Design

The present study employs a qualitative research design. Qualitative research is based on the assumption that individuals actively engage in the construction of their social reality and that research should provide individuals with the opportunity to describe studied phenomena in their own terms, such that they can contribute to the exploration and conceptualisation of these phenomena (Boeije, 2010).

Little is known as of yet about how people in South Africa construe suicidal behaviour and a qualitative research design was chosen in the current study to survey a slice of the phenomenological landscape of suicidal behaviour. Furthermore, information yielded from qualitative research is not limited to predetermined questions, but stimulates the production of rich and detailed descriptions, which allows for interpretive rendering of the studied phenomenon (Boeije, 2010). Gavin (2011) puts this aptly: "we all have a different view of reality, and qualitative methods equip us more readily to access such subjective perceptions" (p.53).

Lastly, the choice of a qualitative design was motivated by an indicated need for qualitative research in the field of suicidology. Contemporary research on suicidal behaviour

is predominantly quantitative in nature. Hjelmeland and Knizek (2010) report that across the three main international suicidological journals ("Archives of Suicide Research", "Suicide and Life-threatening Behavior" and "Crisis") only about 3% of all research articles employed a qualitative methodology during the period of 2005 to 2007.

Opposition to the dominance of quantitative research methodologies in the field of suicidology has been expressed by a number of scholars. One of the first to radically challenge Durkheim's quantitative approach to studying suicide was Douglas (1967), who maintained that suicidal behaviour can only be understood by studying the definitions that social actors provide about the phenomenon.

More recently there has been a call for more qualitative research. Lenaars (2002) argued in a special issue of "Archives of Suicide Research" that due to the multidimensional and context-dependent nature of suicidal behaviour, both quantitative and qualitative approaches are needed to bring the field of suicidology forward. Furthermore, Hjelmeland and Knizek (2010) called attention to investigating subjective meanings of suicidal behaviour in their recent article "Why we need qualitative research in suicidology". The authors argued that the unilateral focus on quantitative methodology has led to a "dead-end of repetitious research" (p.74). Most quantitative research in suicidology is invested in *explaining* the underlying causes of suicidal behaviour by using hypothesis-deductive or experimental methodologies. However, this approach is reasoned to contribute little to our *understanding* of the different meanings assigned to suicidal behaviour across different cultural contexts, generations and time. Hjelmeland and Knizek (2010) argue that by neglecting the production of qualitative research on suicidal behaviour, the field of suicidology deprives itself of an important hypothesis-generating tool and a means of making sense of quantitative data, which is crucial for development of more comprehensive theoretical models of suicidal behaviour and the overall advancement of the field of suicidology.

Despite the identified need for qualitative research in suicidology, the difficulties of qualitative research should also be acknowledged, including such issues as the lack of methodological conventions and standard interview procedures (Silverman, 2010). This renders research findings vulnerable to criticisms of reliability, validity and objectivity (Gavin, 2011). It should be noted however that the latter measures cannot be applied in the same way to qualitative as to quantitative research (Flick, 2009). A number of authors emphasise that in order to assess whether the findings and conclusions of qualitative research convincingly represent the studied phenomenon, a detailed description of the "making of" findings and conclusions - including how participants were recruited, how data was collected and analysed and how researchers minimised the influence of their own subjective perceptions on research process – is crucial (Boeije, 2010; Gavin, 2011, Silverman, 2010). In keeping with these recommendations, all the latter aspects of the present study will be discussed in detail below.

5.3. Recruitment of participants

Participants were recruited using a purposive sampling method. An email was sent to 241 undergraduate male students currently enrolled in the third-year psychology course (N= 149) and the third-year physiology course (N=92) at Stellenbosch University, inviting them to participate in a semi-structured, face-to-face interview exploring attitudes, beliefs and myths about suicidal behaviour. A R40 meal voucher was offered to participants as an incentive to take part in the study.

Emails were sent out twice to the selected groups of male students at an interim of a week. Students who identified themselves to fall into the inclusion criteria (male, between 18-25 years of age) and wished to participate in the study contacted the researcher by email. In total 15 male students responded to the email, 8 from the third-year psychology course and

7 from the third-year physiology course. Two participants from each course withdrew their intent to be interviewed via email, citing a high academic workload as a reason.

Initially, the plan was to send an email to male students enrolled in third-year courses across different university departments. However, due to a higher than expected response from third-year psychology and third-year physiology male students as well as data saturation, this plan was not followed through. It is acknowledged that by including only third-year male students from the department of psychology and physiology, the voices of all male students may not be represented by this study.

5.4. Description of participants

All participants of the present study were males between the ages of 20 and 25 years (mean age= 22) and were enrolled as students at a Stellenbosch University at the time of the interview. The present study's sample therefore represents only a stratum of the South African population and is not representative of the general population.

Within the present study's sample participants differed with regard to a number of extraneous variables, which may have had an influence on their attitudes, beliefs and myths. Inferences about possible relationships between these variables and the attitudes, beliefs and myths of participants could not be made, given the size of the sample and the research design of the study. However, some interesting patterns were observed that provide an important context to the findings:

5.4.1. Experience of suicidal behaviour. Four participants disclosed having attempted suicide once previously, five participants reported suicidal ideation, and four participants maintained that they have never had suicidal thoughts or attempted suicide previously. This pattern of suicidal and non-suicidal behaviour is interesting considering that a previous South African study conducted with students indicated that the majority of students (90%) reported no suicidal behaviour, while about 2% of participants reported having attempted suicide

previously, 3% reported having made specific plans and 5% reported having had suicidal ideation (Porter et al., 2009). Various reasons could be distilled from participants' debriefing on why they have come forward: (1) believing that they are a good source of information for the present study, given their personal experience with or 'insider view' of suicidal behaviour; (2) believing that their experiences can help others and can contribute to the public understanding of suicidal behaviour, and (3) a need to talk about their past suicidal behaviour with a stranger in order to find closure or emotional relief.

The incentive of the voucher was explicitly cited as the main reason for three of the four non-suicidal participants. In the debriefing all non-suicidal participants mentioned that the interview helped them to reconfirm that suicide does not represent an option for them, despite having been faced with difficult experiences.

5.4.2. Ethnicity. For a predominantly white university, the sample was surprisingly diverse in terms of ethnicity: Seven participants were white, four participants were coloured and two participants were black.

5.4.3. Home language. English and Afrikaans were the predominant home languages. Six participants reported their home language to be English, four Afrikaans, one Xitsonga, one Sesotho and one English/Afrikaans bilingual.

5.4.4. Religious affiliation. Almost all participants were Christian, except one who reported being agnostic and two who reported being atheists.

5.4.5. Sexual orientation. In the literature homosexuality is cited as a prominent risk factor for suicidal behaviour (Gilchrist & Sullivan, 2006; McDermott et al., 2008). In the present study the majority of participants were heterosexual. However, three participants reported being homosexual, of which two once attempted suicide previously and one revealed to have had suicidal ideation.

Table 5.1.

Participants' characteristics.

	Age	Ethnicity	Home language	Religious affiliation	Sexual orientation	Experience with suicidal behaviour
Participant 1	22	White	English	Agnostic	Heterosexual	Relative, Acquaintance
Participant 2	20	White	Afrikaans	Christian	Homosexual	Own (Attempt), Acquaintance
Participant 3	21	Black	Sesotho	Christian	Heterosexual	Own (Ideation), Acquaintance
Participant 4	25	White	English	Christian	Homosexual	Own (Ideation), Relative, Acquaintance
Participant 5	23	White	Afrikaans	Christian	Heterosexual	Own (Attempt), Acquaintance
Participant 6	23	Coloured	English	Christian	Heterosexual	Own (Ideation), Relative, Acquaintance
Participant 7	22	White	English	Christian	Heterosexual	Own (Ideation), Acquaintance
Participant 8	23	Coloured	English	Atheist	Homosexual	Own (Attempt), Acquaintance
Participant 9	21	White	English/ Afrikaans	Christian	Heterosexual	Own (Attempt), Relative
Participant 10	22	Black	Xitsonga	Christian	Heterosexual	Own (Ideation), Acquaintance
Participant 11	22	Coloured	Afrikaans	Christian	Heterosexual	Relative, Acquaintance
Participant 12	21	White	English	Atheist	Heterosexual	Acquaintance
Participant 13	22	Coloured	Afrikaans	Christian	Heterosexual	Acquaintance

5.5. Data collection

The interviews were conducted at a time suitable for the participants in the privacy of an interview room situated on main campus. On arrival, the participants received a participant information sheet and consent form (see Appendix D). The purpose and the confidential nature of the interview were verbally reiterated by the researcher. Only upon receiving written consent, the interview was conducted.

The interviews were semi-structured and included questions on suicidal behaviour, questions on suicide vignettes and questions on help-seeking for psychological distress (see Appendix E for the interview schedule). Four different vignettes were available to stimulate discussion, which included the following scenarios: (1) suicide in response to academic pressure, (2) suicide in response to unemployment, (3) suicide in response to relationship problems, and (4) suicide in response to mental illness. Only one or two of these vignettes were selected for each participant by the researcher in order to explore more in-depth attitudes, beliefs and myths that came to the fore in the first part of the interview. Interviews were audio-recorded to allow for verbatim transcription. The researcher obtained consent from the participants to use the audio recorder.

5.6. Data analysis

Thematic analysis was used to analyse the transcribed data from interviews. Thematic analysis is "a method for identifying, analysing and reporting patterns (themes) within the data" (Braun & Clarke, 2006,p. 79). It allows for a systematic and thick description of the data set (Braun & Clarke, 2006) and is suitable for the present study since the aim of the study is to identify specific attitudes, beliefs and myths. The thematic analysis was performed manually, following the process of encoding data as outlined by Braun and Clarke (2006):

1. Familiarizing: The analysis commenced with open coding, which entails repeatedly reading the transcribed interviews to become familiar with the data.

2. Generating initial codes: After an in-depth understanding of the content was gained, initial codes were applied to relevant segments of the data. Review functions in Microsoft Word aided in this coding process.
3. Searching for themes: The different codes generated by collating related data were organized into broader, overarching themes.
4. Reviewing themes: After each theme was scrutinised in relation to the complete data set, a thematic mind-map was created.
5. Naming and defining themes: The relationship between the core theme and subthemes was validated and themes were further refined in order to ensure that they capture the essence of the entire data. Each theme was then clearly named and defined.
6. Reporting: Compelling extracts, which are representative of the core themes, were selected to be incorporated in the report of the analysis.

5.7. Ethical considerations

The present research proposal was approved by the relevant ethics authorities. Ethical clearance for conducting the research was obtained from the Health Research Ethics Committee (HREC) of Stellenbosch University (protocol number S12/05/118) on the 24th of May and institutional clearance for conducting research with students enrolled at Stellenbosch University was obtained from the Division of Research and Planning of the Stellenbosch University on the 13th of June.

Suicidal behaviour is a sensitive subject matter. Great care was therefore exercised in setting up and conducting the interview in a sensitive manner. The questionnaire was developed in communication with the supervisors of the researcher, Dr Jason Bantjes and Prof Ashraf Kagee, and widely published researchers in the field of suicidology, Heidi Hjelmeland and Birte Lao Knizek. Preparation for the interview entailed attending a suicide assessment workshop and practice interviews to ascertain whether questions are clear.

As mentioned previously, participants were asked to complete an informed consent form, indicating that they chose to participate in the study. Furthermore, participants were made aware that their confidentiality would be preserved and that if they would like to withdraw from the interview process at any moment, they have the right to do so. Time was allocated after the interview for debriefing. This time allowed participants to reflect on what they thought and felt during the interview. Participants were also given room to ask the researcher questions and to share any thoughts and feelings that were not talked about during the interview.

Participants were encouraged to seek help at the Centre for Student Counselling and Development or call in at the 24-hour Psychological Crisis Service of the Stellenbosch University if they experienced psychological distress following the interview or wanted to explore psychological concerns more deeply with a psychologist. Details of the counselling centre and crisis service were given to all participants in writing at the end of the interview together with the meal voucher. Although laymen often consider it a risk to speak to people about suicide (because this might "implant" or provoke the thought) this is not supported by research findings. There are a number of studies (for example, Hjelmeland & Knizek, 2004), which have shown that speaking to people about suicide does not increase the risk of engaging in suicidal behaviour and is more often than not considered helpful by research participants.

5.8. Researchers' reflection on the research process

This reflective piece serves to provide a glimpse into how I, as a researcher, made meaning of the research process and how that may have influenced the research process.

5.8.1. About me. I am a 23 year-old, white female, who has recently completed a Bachelor of Science and an Honours degree in psychology. These characteristics may influence the research process. Being a female interviewing male participants may have

resulted in a different gender dynamic compared to a male interviewer. Moreover, it should be noted that coming straight out of an honours programme, I did not have extensive research experience and the present research was in many regards a learning process. Despite certain of my characteristics being potentially problematic, it is possible however that being about the same age as the participants may have contributed to a reduced power differential in the interviews and a greater willingness to disclose sensitive and emotional experiences.

8.1. The beginnings. My motivation to embark on a study on suicidal behaviour was an honours thesis on the topic of depression, which opened my eyes to the need for qualitative research on mental health concerns. I started out the research process with little prior knowledge of suicidal behaviour. Moreover, my personal experience of suicidal behaviour is limited to two friends who have engaged in suicidal behaviour, one of which successfully completed suicide. So in a sense I was a novice in terms of both knowledge and experience. In order to gain insight into the topic I started reading not only academic articles, but also personal accounts and philosophical readings on suicidal behaviour. In addition, I enrolled in a course on community psychology, which helped me to understand suicidal behaviour 'in-context'.

My daily engagement with the subject material resulted in me becoming very conscious of what people around me were saying about suicide (if they ventured to speak about this stigmatised topic at all). I also became aware of cases of suicide on campus and that they were remarkably hushed, which made me wonder about my own ignorance before embarking on this research. My supervisor suggested me to attend a suicide risk assessment workshop and this provided a space for me to integrate my understanding of suicidal behaviour and recognise my own subjective perceptions on suicidal behaviour. My readings on qualitative research at that time made me realise that I am a fundamental component of the research process and in order to minimise bias I needed to put myself in "a frame of mind

appropriate to the naturalistic paradigm" (Gavin, 2011, p.246), rather than being the detached and objective observer that I had been in my previous quantitative research in my honours year.

5.8.2. The interviews. Initially, I had some difficulties securing an interview room on campus. I therefore arranged to meet most participants at a specific location on campus and walked with them to the interview room that I had been able to secure just before the interviews. I discovered that the three minute "side-by-side" walk to the venue was an excellent way to build rapport through allowing for small talk about the weather and studies, for example. By the time participants arrived in the interview room they were relaxed and the interview flowed easily.

During the interview I gave participants room to talk and tried not to interrupt them with verbal encouragers, but rather used body language to signal my attentiveness. Since validity is a key concern in qualitative research, I paid attention to communicative validation, which entailed me summarising participants' views and clarifying ambiguous terminology or explanations (Flick, 2009).

Besides words, much more was said in the interviews. Most interviews were emotionally-laden. The most prominent emotion communicated by participants who had a previous experience with suicidal behaviour was pain, which I chose to contain in the interview space. Participants that did not have an experience with suicidal behaviour were more emotionally detached when they shared their views. Towards the end of the interview I usually observed a waning of energy in the interpersonal interaction. When I sensed that participants had reached this point, I took care to wrap up the interview. I also saw no more than three participants a day in order to be fully present in each interview and also to allow myself time to reflect on the interviews.

Finally, it may be important to note that I conducted the present study's interviews parallel to being interviewed myself at three universities, as part of the clinical psychology masters selection. In that time I thus had to take on the role of an interviewer and interviewee. With regard to this research project, it demanded of me to distance myself from the interviewee role and its emotional associations in the interview space with participants. I managed this and in hindsight I realise that my own experience of being interviewed assisted me to model some helpful interview practices, such as creating a safe space for participants to open up and being attentive to my own and participants' body language.

Transcription and analysis. I encountered little difficulties transcribing of the interviews. The participants spoke clearly and used little colloquial language. All participants were well-versed in English and all chose to conduct the interview in English, although the option of speaking Afrikaans was given to them. At times punctuation was difficult during the transcriptions, because in conversation partipants did not complete their sentences or spoke in run-on sentences. However, listening to certain parts of the interviews several times helped me to discern the sense of what was being said and punctuate the interviews, such that the original sense of the interaction was retained.

Once I had transcribed all the interviews, I was already quite familiar with the content of the interviews and could easily identify broad themes. However, these themes did not wholly capture the essence of the interviews. In order to create a set of themes reflective of the interviews I read and re-read the interview several times to pull out all the attitudes, beliefs and myths about suicidal behaviour articulated by participants. I then grouped these attitudes, beliefs and myths into four different themes. Besides these four themes, I identified two overarching narratives that traverse the latter four themes. In this way I was able to more accurately portray the complexity and interconnectedness of what participants were saying.

The process of identifying themes and subthemes was a lengthy and thought-intensive process. It entailed me to break down the interviews into the smallest units of attitudes, beliefs and myths and then use these units to build themes that capture the essence of what participants were saying. The guidance of my supervisor and numerous discussions throughout the analysis process helped me to approach the analysis in a critical and systematic manner.

5.9. Limitations of the present study

The group of participants who volunteered to take part was diverse in many regards (e.g. experience of suicidal behaviour, race and religious affiliation), but can hardly be taken to be representative of all student males in South Africa.

Of the sample size of thirteen participants, 31% reported to have attempted suicide, 38% reported to have had suicidal ideation and 31% reported no history of suicidal behaviour. This pattern of suicidal behaviour contrasts to that of a recent South African study conducted with undergraduate students by Porter, Johnson and Petrillo (2009), who found that merely 10% of the sample had previously engaged in suicidal behaviour. The attitudes, beliefs and myths expressed by the participants may thus not be a reflection of all young male students. Nonetheless, the interviews provide us with "a slice of the social world from the informants perspective", as Boeije (2010, p. 58) notes.

Moreover, participants were predominantly Christian. The religious attitudes towards suicidal behaviour can thus not be generalised as representative of all religious groups that young South African male students affiliate with.

It should also be noted that the interviews were conducted by a white female in her early twenties. As mentioned earlier, the personal characteristics of the interviewer may have influenced the interview process and outcome. It may be possible that participants may have given socially desirable responses, because they believed that a white female psychology

student would want to hear them speak about suicidal behaviour in a particular way. Moreover, my own experiences of masculinity, death and other personal biases have, albeit subconsciously, influenced the way I guided the interview process, the interpretation of the interviews, the choice of extracts I included and the way I wrote up and made sense of the findings.

5.10. Conclusion

In the present chapter reasons for using a qualitative research design and details of the recruitment, data collection, data analysis and ethics process are described. Furthermore, the researchers' reflection of the research process was presented and possible limitations of the study were considered.

CHAPTER 6: RESEARCH FINDINGS AND DISCUSSION: PART 1

6.1. Introduction

This chapter is a presentation of how suicidal behaviour is understood and evaluated by a group of thirteen male university students between the ages of 20 and 25.

At the outset of this chapter it should be pointed out that the participants of the present study differ with regard to a number of variables, including experience of suicidal behaviour, age, ethnicity, languages spoken, religious affiliation and sexual orientation. These variables may have influenced participants' understanding and evaluation of suicidal behaviour (see Chapter 5, Table 5.1. for a description of participants). However, since suicidal behaviour is a complex and multifactorial behaviour that cuts across nosological and socio-demographic boundaries, imposing such predetermined structures on the present study's qualitative data is not deemed appropriate.

Analysis of the data revealed that despite some contradictions, numerous shared attitudes, beliefs and myths could be identified across all interviews. These attitudes, beliefs and myths about suicidal behaviour can be clustered into four themes: 'Moral acceptability of suicidal behaviour', 'Perceived causes and risk factors of suicidal behaviour', 'Perceived motives of suicidal behaviour', and 'Perceived prevention and protective factors of suicidal behaviour'. Traversing these latter four themes is also an underlying narrative of belonging, named 'Apart or a part: Belonging and suicidal behaviour', and hegemonic masculinity, named 'Dying to be a man: (Re) negotiating masculinity'.

In this chapter the former four themes are described and where contradictions between the different participants are observed, these are highlighted. Verbatim extracts from interviews are included to illustrate and substantiate findings and preserve some of the richness of the original data. These extracts are labelled with pseudonyms for reasons of privacy and confidentiality. The present chapter also incorporates a discussion of the research

findings within the identified themes of moral acceptability, perceived causes and risk factors, perceived motives, and perceived prevention and protective factors of suicidal behaviour. This discussion lays the basis for a more focused discussion in Chapter 7 of the underlying narratives of 'Apart or a part: Belonging and suicidal behaviour' and 'Dying to be a man: (Re) negotiating masculinity and suicidal behaviour'.

6.2. Theme 1: Moral acceptability of suicidal behaviour

This theme is concerned with participants' evaluation of suicidal behaviour as acceptable or unacceptable and the arguments they present to support their evaluation. The first part of this section centres on how participants make sense of suicidal behaviour as a choice and the second part is concerned with participants' acceptance of suicidal behaviour under specific conditions.

6.2.1. The choice "to be or not to be". In line with previous studies that investigated young people's attitudes towards suicide (e.g. Boldt, 1982; Miller et al., 2001; Zemaitiene & Zaborskis, 2005), a predominant attitude in the present study is that suicidal behaviour is a personal choice or right. Participants view humans to be agents, who have the capacity to *choose* between ending or resuming their life and the capacity to *act* on their respective choice. Framing living and dying as a choice has implications for how suicidal behaviour is understood and evaluated by participants:

(1) Firstly, by representing suicidal behaviour as a choice, there is an assumption that suicidal behaviour is a *rational* behaviour, which is preceded by a careful calculation of the costs and benefits of the behaviour. Several participants depict suicidal intent to be preceded by such a rational contemplation of pros and cons. For example, participant 5 says: "So it kind of gets into a pro's and con's factor thing, you know. So if I do live and if I don't (…) So you weigh these things and you are just actively seeking a reason" and participant 12 says:

"I think [people commit suicide] mainly when the reason for not living outweighs the reason for living."

However, by portraying suicidal behaviour as rational, the irrationality and ambivalence that commonly accompany suicidal behaviour is obscured. Participant 9 describes how biased his seemingly "sensible" decision-making process was in the moments before he tried to roll his car:

> I thought to myself: "Well, pros: this, this, this (…) obviously, the huge con is "I might die", but you tend to like smudge that and think: "No, I'm not gonna go that far. I don't want to kill myself, I just want to hurt myself". You smudge it out in the sense of "Ag, it is ok. That won't happen to me." You decide to rather bend it – bend your reality to suit you. (…) For half an hour to an hour I thought it through and explained it for myself until this hugely stupid idea made sense. Afterwards you obviously think to yourself : "Holy crap!", suddenly the wool is pulled off your eyes.

It can be argued that participants portray suicidal behaviour as a rational personal choice because there is something to be gained by constructing suicide in that way. Roen et al. (2008) posit that it may be a way for participants to distance themselves from the inexplicability of wilfully ending one's life and to affirm that it is not a choice they would make, but one that a suicidal "other" would make based on *their* own rational decision-making process. This distancing and "othering" is observed especially in interviews with participants who have no reported history of suicidal behaviour, for example in the extract of participant 1:

> So if you and I have the exact same situation, lived in the same situation, but I had the mechanisms and you didn't, who am I to say that you should deal with it, because I can't begin to fathom how you are feeling inside, how your mind works.

(2) Secondly, representing suicidal behaviour as a choice means that the person engaging in the act is *responsible* for that choice and can be *judged* for the consequences. Participant 10 communicates this point:

> I think you have a choice. … He [God] gave us one thing: Choice. The reason why we have right and wrong is choice. … And there is no one to blame but you, because you choose that.

Beyond being autonomous agents, people are considered to be relational agents, who have a moral responsibility towards others and God. Several participants argue that if a person truly loves their family and friends they would not commit suicide, since suicide casts hurt and the shame on family and friends. Individuals who nonetheless engage in suicidal behaviour are considered selfish by all participants (including participants that previously attempted suicide) and to that effect blameworthy. So even if individuals exercise their autonomous right to kill themselves, they are judged for failing to factor into their decision the potential negative interpersonal consequences. A quote by participant 5 illustrates this ideological contradiction of individualism and utilitarianism. Take note how the participant uses criminal terminology to underscore the immoral character of suicide:

> I do think that everyone has their own choice to take their life, but morally again it is not fair on the people that you leave behind, I think. You know, because you are basically stealing yourself or stealing from them as well, because there is some sort of connection or relation to you. So you are not a being unto yourself only, but you are a being of somebody else as well and you steal from them if you take your own life.

Further, some participants argue that when a person does *not* have a support system and no one to mourn their loss, the ethical argument of utilitarianism falls away and the suicide is justifiable. For example, participant 10 believes that in such a case "it is a very easy choice to make in terms of no one is gonna miss me when I am gone", participant 13 says:

"So if your family is not wanting to speak to you and your friends are not wanting to speak to you, then I guess you think that suicide is the only option".

Besides interpersonal-moral arguments, some participants signify their disapproval of suicidal behaviour by drawing upon religious-moral arguments, for example "suicide is against God" and punishment for suicide is eternal damnation in hell. Participant 7 says:

> Probably the fear of dying [stopped me committing suicide], because if you are not ready to die and then you die consequences could be quite bad. I don't know how to explain it. If you are not "saved" as it were and you die, then you could possibly go to hell, which is not a very good thing. So that sort of aspect of just fear stopped me.

The belief that God has a purpose for his life is cited as the main reason by participant 3 for why he has not acted on his suicidal thoughts. Moreover, participant 2 believes that separating oneself from God is like suicide – "spiritual suicide":

> Many times instead of killing myself - like suicide, I thought of killing myself spiritually like let's just go to Buddism, cos I'm really attracted to Buddism, or let's just become atheist or something, even though I believe in God fully and I love him so much. Like even once I told him just go away.

In summary, it appears from the interviews that while suicide is considered a rational *individual* choice, it is judged as unacceptable on the basis that it is not a rational *relational* choice. Participants believe that life does not merely belong to the individual but to close others and to God. However, if belonging is thwarted, participants view suicidal behaviour to be acceptable.

6.2.2. Conditional acceptability. Two participants (both non-suicidal) view suicidal behaviour to be incomprehensible and unacceptable under any given circumstance (a moral simple view). One participant, participant 12, draws on the authority of his religion to support his non-permissive attitude: "I don't see it as being right. Ok, I am Catholic as well. So with

our religion we don't consider suicide as correct." However, all the other participants regard suicide to be understandable to them and God in certain situation. This moral noncee viewpoint was also found in a South African study by Mayekiso (1995) with secondary school students (*N*=100, ages 15 to 19 years).

Participants oftentimes regard a situation to be understandable when they can personally relate to it, such as academic failure and financial difficulty in the family. Furthermore, mental illness with psychotic symptomatology is regarded an understandable cause for committing suicide, because people suffering from such a condition are thought to be "incompetent to make choices" and therefore they cannot be held responsible for their actions. However, several participants note that if a person with a mental illness is treated and still engages in suicidal behaviour, it is not understandable and blame comes into play again. For example, participant 5 says:

> I think if the person [with mental illness] is left untreated and without help, you can say it is understandable, because in the right mind-set it probably wouldn't have occurred to them.

Contrary to a study with Ugandan men by Knizek et al. (2011) and in line with a study by Dahlen and Canetto (2002), Cato and Canetto (2003) and Stice and Canetto (2008), suffering from a severe or incurable illness (for example HIV) is regarded an acceptable reason for completing suicide by the majority of participants. The extract below portrays how physical pain is considered a more acceptable reason than mental pain for engaging in suicidal behaviour:

> I think it is ok for people to be put out of misery if pain is the reason …I feel anything physically to that extend. But mentally, I believe that mentally everyone is redeemable. (Participant 5)

Moreover, some participants advocate for euthanasia (assisted suicide) rather than suicide to end one's painful existence. Participant 2 says:

> Seeing that I was there, I think this makes me think of that thing where you pay and people give you pills or they inject you with something. Like "grace". … I thought of stuff like that as well. Maybe I can just pay people to inject me something and then I can just die peacefully. But I think it is your choice.

What is interesting about how participants talk about euthanasia is that euthanasia is not framed as being morally wrong, but is instead described using non-judgmental terms such as "peace", "grace" and "dying with dignity". The reason for this difference in moral judgment between euthanasia and suicide may be threefold: (1) euthanasia is regarded to be a rational act and is thus not as morally reprehensible as suicide (Clarke, 1999; Witte et al., 2010), (2) the "agent of death" is not the suicidal individual per se, but another person who is willing to carry out the act on behalf of the suicidal individual. This means that suicidal behaviour is no longer a personal, but an interpersonal act and hence the blame does not fall solely on the suicidal individual, and (3) euthanasia is thought to occur in a more "controlled environment" , while suicide is seen to be an impulsive and unpredictable behaviour. Previous research on euthanasia and suicide has similarly shown that euthanasia is seen in a morally more favourable light than suicide (e.g. Cleary & Brannick, 2007; Bachman et al., 1996; Witte et al., 2010). Since the 1990's there has been increased media coverage on euthanasia, which may have contributed to a more favourable public attitude towards euthanasia (Witte et al., 2010).

Taken together, participants judge suicidal behaviour based on four criteria: rationality, relationality, familiarity, and ill-health. In participants' discourse there is a strong tension between rationality and relationality. On the one hand, participants understand suicide to be a rational personal choice and acceptable from that view. On the other hand,

they argue that suicidal behaviour is a transgression of family, community and religious norms and therefore blameworthy. This finding contradicts previous research in African countries, which found a strongly negative attitude towards suicide, due to endorsement of religious and communal morality, instead of a western individualistic morality (e.g. Eshun, 2003; Lester & Akande, 1994). The endorsement of both individualistic and utilitarian ethics by participants of the present study may be reflective of the mixed individualist-collectivist culture they live in, but may also be attributed to the nature of the sample. Previous studies indicate that men and individuals with a previous history of suicidal thoughts and attempts may have a more accepting attitude towards suicide and are more likely to support the view that people have the right to die (Dahlen & Canetto, 2002; McAuliffe et al., 2003). Finally, there is also a possibility that participants' double ethical standard is a social desirability response – a normative response, rather than an individual belief or attitude.

Moreover, familiarity with certain situations, such as the academic failure and the shame experienced thereof, has been found to influence participants' acceptability of suicidal behaviour. Familiarity is also considered an important factor by Agnew (1998), who says: "Individuals …will be more likely to state that suicide is an acceptable solution to certain problems when *they* have problems that cannot be solved through conventional channels" (p.207).

Finally, participants' judgment of suicidal behaviour is influenced by their evaluation of ill-health of a suicidal person. A painful physical disorder appears to be a more acceptable reason to complete suicide than a mental disorder, such as depression or bipolar disorder. One reason for this may be that ending one's life in response to mental pain is associated with irrationality, which contradicts the masculine ideology of rationality and rational suicide (Canetto & Sakinfsky, 1998). In contrast, suicide in response to unbearable physical pain is understood as a rational choice. Stice and Canetto (2008) posit:

> (…) for men the acceptability of suicide under conditions of physical illness may be amplified by dominant ideologies of masculinity, with their emphasis on youthfulness, physical power, physical autonomy and physical integrity (Spector-Mersel, 2006). (p.21)

There is also a belief that mental illness (such as depression and bipolar disorder) can be sorted out "rationally" by getting medication and going to therapy and should therefore not be a reason to engage in suicidal behaviour. Nevertheless, severe mental illness (such as schizophrenia) is considered acceptable by the present study's participants on the basis that "it is the disease that makes it happen" and the person is not actually at fault. This attitude has also been found by previous studies (e.g. Skogman, 2006) and reinforces the idea that suicide is an epiphenomenon rather than a phenomenon in its own right (O'Connor, 2011).

6.3. Theme 2: Perceived causes and risk factors of suicidal behaviour

This theme is concerned with participants' subjective interpretations of the causes of suicidal behaviour. The findings in this theme are organised starting with extra-personal causes and funnelling to inter- and intrapersonal causes.

6.3.1. Social, cultural and economic causes and risk factors. The subtheme centres on participants views on social, cultural and economic causes. Four core ideas relating to this subtheme could be identified: 'Trapped in social and cultural transition', 'A land of opportunity?', 'Just another death' and 'Contagion', which will be elaborated on below:

6.3.1.1. Trapped in social and cultural transition. In many countries extensive social, political and economic transitions have been associated with increased rates of youth suicide (Cleary & Brannik, 2007). The participants interviewed in this study grew up during the period of dismantling apartheid in South Africa and thus spent a significant part of their lives in a context of considerable political, social and cultural transition. Three participants mention that the state of limbo is a reason for elevated rates of suicide amongst their

generation. They raise the concern that it is difficult for young people to form an identity in a context that suffers itself from a "fragmented identity". This idea relates to Durkheim's (1897/1951) concept of anomie suicide (suicide in response to lack of social regulation). Participant 4 says:

> I think my generation was put in a very difficult position to find your feet and to find placement, because we weren't following on from something. In a way we were the sample (...) There is a complete shift of values and norms in a society and I feel that sometimes as a young person it helps so much to have a set of values and norms and system in place that is constant. When that system is interrupted it creates confusion, it creates inconsistency in the individual, and it just vents itself in very strange ways.

Moreover, two participants believe that acculturation may play a role in young people's suicide, which ties in with Durkheim's (1897/1951) concept of egoistic suicide (suicide in response to lack of social integration). Besides, Schelbush, Vawda, & Bosch (2003) have previously observed that acculturative processes after apartheid represent a social risk factor for suicidal behaviour. The extracts below speak to the idea of acculturation:

> I think that might be a reflection more of the times we are living in (…) now you still have a white culture, but everything your parents are telling you is not in place anymore. (Participant 5)

> (…) we are moving to that situation and the era where we have shifted from our culture to adopting the western stand. You wanna adopt the style of the celeb you like. (…) . So I think the influence of media and the broken traditional ties. We are dispersed now, you are no longer living where you are born. You are moving to some place like I am now. I'm studying here and I'm gonna adopt the culture here. (Participant 3)

6.3.1.2. A land of opportunity? Some participants reveal that currently people in South Africa are disillusioned, because of unfulfilled promises of education, employment, health care and housing eighteen years after apartheid. In their article on suicidal behaviour amongst black South Africans Schlebusch et al. (2003) also highlight that high social, political and economic expectations not realised may be related to suicidal behaviour. Participant 12 argues that the disillusionment resulting from unmet expectations causes many young people to "lose their way" and to engage in self-destructive behaviours. Other participants claim that the current education system in South Africa is "killing" young people, because it denies them realistic chances of access to tertiary education and employment. Participant 3 says:

> I think also our government is really failing our youth, because right now you go to tertiary level, there are these colleges here and then at the end when you want to get a job, it is not recognised. It is of a low standard, but yet they are still making those colleges, like FET [Further Education and Training] colleges, and they really kill some of them, because you went there to study for three years and then they don't recognise your degree or diploma. So you see I think it is one of the reasons why our youth commit suicide. We need to up our education system so that we can get the jobs.

6.3.1.3. Just another death. Burrows and Laflamme (2008) suggest that exposure to high levels of violence in South Africa may be linked to increased levels of youth suicides. Similarly, participant 6 believes that men in South Africa more readily engage to suicidal behaviour, because there is a general disregard for human life and a desensitisation to violence in South Africa:

> Some people are desensitised to it just because of violence as well, like we see on TV and like the whole culture of South Africa is just that it is another life. I think that is one of the reasons that suicide is so high amongst men.

6.3.1.4. Contagion. Finally, several participants point out that representations of suicidal behaviour in the music industry, popular youth culture and the internet hold a danger of young people (especially teenagers) imitating the behaviour, which supports Phillip's (1974) contagion theory of suicide and Kral's (1994) theory of suicide as social logic:

> I don't think there is a teenager in our generation that hasn't been exposed to the idea and I think in the 90's and in the early two thousand there was a very much punk culture expressed through MTV and very hard rock and you were exposed to music legends, who were committing suicide. (Participant 4)

> I believe it [a friend's suicide] was peer pressure and music. I'm not sure if you are familiar with Marylin Manson, but he actually tells you if you can't anymore just give it all up, give it up. (Participant 5)

> I even went on "Google" to check for ways to commit suicide. It's kinda weird people actually post stuff like that and it kinda freaked me out cos the stuff is just so horrible and now that it is there in my head, it's there and I can just take it and do something with it. (Participant 2)

Taken together, it appears from the interviews that young people's *experience* of socio-cultural instability, unfulfilled promises, thwarted belongingness, triviality of life and suggestibility of suicide, rather than *social factors per se*, give rise to suicidal behaviour. Previous research has predominantly focused on investigating the statistical relationship between suicide rates and social factors and this has been helpful to make sense of how suicide rates differ across different contexts and time. However, this approach cannot capture the experience of young people's relationship with their broader social context and how this

experience may motivate some young people to engage in suicidal behaviour and others not (Mokros, 1995). It may be valuable for future research to further investigate qualitatively how the *relationship* between the individual and the broader social context, rather than *social factors as such*, may encourage (or discourage) the idea of suicidal behaviour.

6.3.2. Masculinity. A common thread running through all the interviews is the idea that men engage in suicidal behaviour in response to unbearable pressure to meet social and cultural expectations of being a 'respectable' man. Participants explain that men have a tendency to strive to live up to masculinity stereotypes, even at the cost of their own psychological and physiological wellbeing. Male suicidal behaviour is related to a number of concerns associated with masculinity by participants, including: "Supressing instead of expressing emotions", "Coping fine alone", "Doing it the manly way", "The breadwinner predicament" and "Women empowerment and loss".

6.3.2.1. Supressing instead of expressing emotions. All participants raised the concern that the stereotype "men don't cry" is contributing to men's higher likelihood of completing suicide. They explain that men do not express emotions, especially towards other men, because it threatens their masculine identity. Showing emotion is perceived to be a feminine trait or a sign of homosexuality and consequently an undesirable characteristic to take on as a heterosexual male. For example, participant 1 says: "A lot of men will not want to go and express their emotions for fear of being stigmatised [as homosexual]". Participant 3 is adamant that men should hide their emotions, but admits that it is not conducive to his own psychological wellbeing. He says: "It's eating me inside. It's eating me inside." Several other participants cite men's avoidance to give voice to their distress as reasons for them to engage in suicidal behaviour. For example, participants 12 and 4 say:

> Men always feel that they have to be strong and they have to sort of carry the weight and just shrug it off and keep going. (…) I think men are ill-equipped to deal with

> their emotions a lot of times. So they just bundle up and that will be the end result. (Participant 12)
>
> I think men are more likely to commit suicide than women because there is also an attitude or a culture that I've experienced where men are not as expressive as woman. It is easier for women to congregate and just have a "bitch-and-moan session". I can't say that men don't do the same, but it's considered demasculinating for a man to express insecurity, to express failure, to express fear. (Participant 4)

All participants emphasise that in the long-term men cannot sustain "bottling up" their emotions and will have to express them at some point. This point is described as impulsive, overwhelming and self-destructive by participants using metaphors, such as breaking of a dam wall, cracking, snapping, and being driven over the edge and hitting rock-bottom. Participants' metaphors tie in with Shneidman's (1993) idea of perturbation or "psychache" – the point at which psychological pain exceeds a person's threshold and the person decides to diminish or end this pain. The extracts below capture this idea:

> It is that it gets too much and they [men] never ask for help until a point where they crack. Everyone is going to crack at some point, some later than others (…) It is literally an all of a sudden the dam wall breaks and everything just comes out and it is just this huge, massive release whatever of cooped up anger, frustration and shame, whatever it is. So I would definitely say that is the problem when it comes to guys and suicide. (Participant 9)
>
> I think it takes a lot more to drive a man psychologically over the edge and that builds up, because I believe that men don't speak a lot more about their feelings. They are more likely to hold up more anger and frustration than women and I think that is one of the reasons probably. (Participant 6)

6.3.2.2. Coping fine alone. All participants believe that suicidal behaviour can be attributed to men being too proud to seek help when they are distressed. Participants say that it is also difficult for other people to detect when men are in distress, because they are so practiced at hiding it. Accessing formal sources of support, such as psychologists, is thought to be resisted by men because it means admitting that they are not capable to solve their problems on their own.

Moreover, participants say that instead of seeking help men cry alone in their room, try to ignore their problems, or engage in other behaviours that are deemed acceptable for men, such as excessively using alcohol and drugs to blot out their distress, engaging in risk-taking behaviour or being aggressive and violent. Participants say that these behaviours may pose a risk for suicidal behaviour. For example, alcohol and drugs may facilitate an impulsive suicide, and aggression may be turned against the self. Participant 5 describes that he wished to die, but did not want it to be seen as his fault. Instead of explicitly engaging in suicidal behaviour, he engaged in a number of risk-taking behaviours to disguise his intent:

> So you are getting into high risk behaviour – you don't want it to be your fault, you are looking for something to happen. …. I would start drinking and I would have a beer in the clubs and then I would look for this high risk behaviour, I would start to jog … I would just jog through [town] at four o'clock in the morning and I tried to get mugged once. The situations were so … it was those themes of being alive. That is how I described it back then. … After two wrecked cars nothing happened to me.

Besides participant 5, participant 9 also tried to disguise his suicide as a car accident. This supports predictions that the suicide rate is possibly much higher amongst young people than is presently reflected in epidemiological research (Berman & Jobes, 1991).

6.3.2.3. The breadwinner predicament. One widespread gender stereotype mentioned by participants was that the man is the breadwinner, who provides the family not only with

necessities but also luxuries. Participant 8 points out: "If you are 30 or 40, you have to have kids, you need to buy your wife a brand-new house and you have all these expectations from society itself." All participants describe that young men feel that a lot of responsibility rests on their shoulders – responsibility that is often difficult for them to fulfil in the face of lack of study opportunities, lack of finances to study, unemployment and job retrenchments in a time of financial recession. Participant 8 describe these difficulties as a burden to both young men and a possible reason for why they engage in suicidal behaviour.

> From 18 to let's say 25 you are under so much pressure. You are starting your tertiary education and you need to start looking at future plans. You have your girlfriend and you know that you need to now start finishing up and then you need to buy a home and you need to start fulfilling your roles now. So you are under a lot of pressure at that stage in terms of what you gonna do with your life, because you wanna start your life. That pressure could obviously lead to suicide if you can't fulfil those things in due time. (Participant 8)

6.3.2.4. Women empowerment and loss. Several participants express a strong disdain for the gender equality movement, because it means that men are stooped down from their previous position of power. Participants feel that having less power is incongruent with what is socially and culturally expected of them as men. For example, men are expected to be the breadwinners, but paradoxically have to compete for jobs with women.

> I don't think men get their ways as well and that drives them over the edge probably (…) they [women] are given more rights now and so they [men] have to share that kind of equality. (Participant 6)

> Well, I guess pressure is one of the biggest factors [for suicide amongst men]. Like your culture is saying the man is the provider of the family, the man is the stronger one and everything. And then on the other hand, the whole society is giving woman

> all these equal rights and this power to be heard and everything and that kind of takes the man off his podium, where I think he should be. He should be the head of state, he should be in a power position. (Participant 5)

Participants describe that the redistribution of power brought about by gender equality movements has resulted in a different relationship dynamic between men and women. Men feel that more blame and responsibility is levied at them now that they do not hold a role of power and dominance anymore. Furthermore, negotiating power dynamics in romantic relationships is believed to have become more difficult for men, particularly when women are educated and financially independent. Participant 2 says that men "have this thing to be for the women", which puts immense pressure on them, and impacts on men's self-worth:

> We [men] feel inferior … sometimes it's like nowadays it's 50:50. So women when they do succeed, they succeed better than men. So you might see it as a challenge. We are going out together … So you wanna be in charge and the person who is educated and all, who has money, is like independent. (…) You feel that you are not a man enough. So I think it is one of the reasons [to commit suicide]. (Participant 3)

6.3.2.5. Doing it the manly way. Why are men more likely to complete suicide than women? Participants understand this phenomenon in terms of gender stereotypes and roles:

Firstly, men are believed to use more violent means of killing themselves than women, because they are more determined and less scared than women and because they don't want to be faced with the shame of having failed at suicide. Participant 6 says: "I think men can be more vigorous about it. They might take the extreme and make a real effort" and participant 8 says: "Men, we can't cry and we can't talk about our feelings and sometimes they just feel like…we either go through with it [suicide]… because we don't wanna be labelled as a "woosi" … ja, rather just go through with it." According to Jaworski (2010b)

for men "the fear of being emasculated through survival, is related to being feminine, which in turn becomes a sign of abjection" (p.57).

Secondly, men are seen to be less socially connected and less attached to their role as a parent than women. Consequently, suicide is believed to be more acceptable and thus also more likely for males than for females. Interestingly, there is also an idea that women are innately endowed with more of a life driving force than men. Participant 7 says:

> I suppose if a woman has children then she can't really abandon her children. That is the instincts that she gets when she becomes a mother. Maybe that also prevents women from succeeding and actually even attempting in the first place.

Taken together, it appears from the interviews that there is a strong expectation of men to behave "manly", which is policed by other males (fathers and male peers) and is demanded by females. In accordance with Connell and Messerschmidt (2005), this most highly regarded form of masculinity is called hegemonic masculinity. Participants of the present study define hegemonic masculinity as being invulnerable, self-reliant, rational, powerful, employed, and heterosexual. They explain that men strive to live up to the hegemonic masculinity ideal, albeit at a psychological and physiological cost. Connell and Messerschmidt (1995) refer to the health compromising behaviours performed by men to signify a masculine self as "toxic practices". Participants mention a number of such "toxic practices" that are implicated in suicidal behaviour, including nondisclosure of emotions, help negation and engagement in maladaptive coping behaviours, such as excessive alcohol use, aggression, violence and risk-taking behaviours.

A number of previous studies on male depression and suicidal behaviour report similar findings. Cleary (2012) found in her qualitative research that young male participants that previously attempted suicide actively concealed their distress to evade the perceived stigma that emotional vulnerability implies weakness and femininity. Moreover, a qualitative

study on male teachers and students experiences of depression by Brownhill et al. (2005) found that men typically "act in" in response to feeling depressed, which leads to a "big build" of emotional pain over time and subsequent engagement in risk-taking, aggression, violence or in some cases suicidal behaviour. Finally, Emslie et al. (2006) describe how men, rather than admitting to having depression and seeking help, resort to self-medicate their depression with 'coping' behaviours that are in alignment to hegemonic masculinities, such as excessive alcohol use, believing that it will restore their masculine image.

In addition to understanding suicidal behaviour as a result of living up to the hegemonic ideal, participants view suicidal behaviour to result from *failing* to live up to hegemonic masculinity ideal of being employed, being able to provide for the family and acting as authority figure in the family and work environment. Failure to be a "man" is described by participants to be brought about by factors such as unemployment and changing gender dynamics. These factors have also been identified to be implicated in male suicidal behaviour by quantitative research (see Platt, 2011) and recent qualitative research (e.g. Cleary, 2012). Cleary (2012) reports that unemployment and economic disadvantage increase the likelihood of men engaging in alcohol and drug uses, which in turn increases their risk for suicide, while Oliffe et al. (2012) found that by connecting with masculine protector and provider roles men are able to counter suicidal behaviour. In a recent report for the Samaritans, Chandler (2012) notes that "men who are unemployed lack an important source of 'valued' masculine identity, and therefore may be at greater risk of a variety of other risk factors for suicide, including depression, social isolation, alcohol and drug use" (p.114). According to Chandler (2012), unemployment increases males' vulnerability for suicide, because it represents a "double failure" to men: a failure of the masculine ideal of being employed as well as a failure of being the providing father.

Moreover, changes in the labour market, including women empowerment and increased job demands, are hypothesised by authors, such as Möller-Leimkühler (2003) and Payne (2008), to explain men's higher rates of suicide. The greater involvement of women in employment means that the masculine self is threatened, because not only do men have to compete with women for jobs, but there is an increased expectation of men concerning romantic relationships, child-rearing, education and work (Chandler, 2012; Möller-Leimkühler, 2003). Interestingly, a recent South African ethnographic study conducted by Niehaus (2012) suggests that the main precursor for male suicide is to "escape from a thwarted dominant masculine position" (p.). He writes:

> Men fantasise about the powerful identities that are inscribed in gender hierarchies, and commit themselves emotionally to these identities, and have a vested interest in them. But these investments are often thwarted. A crisis of selfrepresentation ensues when men face contrary expectations, and when other persons refuse to take up or to sustain subject positions vis-a-vis themselves. The result is a crisis of self-representation. Moore (1994) contends that violence reconfirms the nature of masculinity otherwise denied, and represents a struggle for the maintenance of certain fantasies of identity and power. Self-eradication offers another resolution to the crisis of self-representation. (p. 70)

Finally, participants draw on gender stereotypical ideas, such as bravery vs. cowardice, strength vs. weakness, and independence vs. dependence, to explain why men are more likely than women to complete suicide. The present study's finding are in line with Canetto (1997) and Lester (1995), who posit that fatal suicide is understood as more masculine and consequently brave and rational than non-fatal suicide, while non-fatal suicide is seen as more feminine and weak. Canetto (1997) argues that these "gendered scripts" influence how suicide is understood, contemplated and performed differently by men and

women. Participants of the present study are found to strongly align themselves with these "gendered scripts" and this influences their acceptability of suicide, as described in the theme 'Moral acceptability of suicidal behaviour' above.

6.3.3. Sexuality. In this section participants' views on the link between homosexuality and suicidal behaviour are presented.

6.3.3.1. Suppressing homosexuality in a homophobic context. At first glance it may appear that homosexual individuals may be exempt from many traditional masculine stereotypes that are problematic in terms of suicidal behaviour. For example, participant 1 says: "I feel like crying for straight men, because they can't be who they want to be. Kurt Darren [Afrikaans singer] is holding them back and die Bokke [national rugby team] is holding them back, you know." However, a closer look reveals that homosexual participants experience an immense pressure to suppress who they are and what they feel in order to avoid being ostracised by other people. Several participants (both homosexual and heterosexual particpants) mention that because of the lack of tolerance towards homosexuality in South Africa, homosexuality represents a clear risk factor for suicidal behaviour:

> Another big example [for why men commit suicide] would be young white Afrikaans males who are homosexual, having nowhere to go and not being able to come out to their parents. They have nowhere else to go because of all the pressure put on them. (Participant 1)
>
> Ok, I recently came out of the closet and I think that is the thing that you probably see in your research as well, especially gays is committing suicide a lot and all of that. And it's still kind of difficult to make peace with this and … that is probably a reason why guys also commit suicide. Not like all of them are gay, but they got these feelings stored up inside, you know. They can't be the man they want to be in terms of maybe

> I want to be a bit softer, or maybe I want to be expressing myself more in this way or that way. (Participant 2)

Participants explain that continuously hiding one's homosexuality (especially from family) is emotionally taxing and may contribute to some homosexual individual's to decide to end their life. Participant 4 choses the words "decay", "rot" and "deterioration" to communicate his experience of supressing his sexuality as analogous to an inner death:

> In my personal experience I had to come to terms with my sexuality, which I was aware of from a very young age. (…) That is many, many years of repression and it manifests rot, it manifests deterioration in you, in a person's character. (Participant 4)

6.3.3.2. Religion and homosexuality. Homosexual participants also struggle to make sense of their homosexuality in the context of a church community that prohibits homosexuality. This may cause them to feel isolated and trapped without an escape, which poses a risk for them engaging in aggression and suicidal behaviour. Participant 5 and 2 each share a personal experience, which strongly conveys this idea:

> I just felt terrible at times and you sit in church or confirmation and people is talking from the bible about being gay, how wrong it is and you sit there and you are thinking: "Well, why am I here, why not go and cause destruction somewhere else, because I am already not going to heaven and stuff." So the whole religion and my parent's sort of rules and stuff all created me being an unstable teenager. That is why I felt trapped, couldn't express who I am. (Participant 5)
>
> (…) once in church I had this very high moment (…) but then in that moment I felt super suicidal. I was thinking … you know, many churches are obviously against homosexuality … and it's like, I'm standing here and everyone is going crazy for God and there is a person with pain in the middle, who wants to commit suicide. You know, and nobody even sees that. That kind of was very contradictory for me,

because that is not love kind of in the sense that you worship a God of love. (Participant 2)

Participants' perception that that homosexuality is a risk factor for suicide is congruent with the empirical findings of previous studies. Bagley and Tremblay (2000) found that homosexual individuals have a higher likelihood of engaging in suicidal behaviour than heterosexual counterparts. Moreover, other studies indicate that the experience of isolation stemming from non-disclosure and homophobia is particularly prominent amongst homosexual suicide attempters (Gilchrist & Sullivan, 2006; Remafedi, French, Story, Resnick, & Blum, 1998; McDermont et al., 2008).

6.3.4. Interpersonal factors. When contemplating suicide, interpersonal relationships are identified by participants to be one of the key deciding factors in following through with or diffusing suicidal ideation. Participants describe that suicidal behaviour is caused either by a lack of close relationships (no social support) or by negative relationships, including physical and emotional abuse, interpersonal conflict and negative peer interactions. Below I will present findings with regard to absent relationships and negative peer interactions in more detail:

6.3.4.1. Lack of close relationships. Having no intimate relationships to fall back on for emotional support is believed to be strongly related to suicidal behaviour by all participants. For example, participant 3 shares how his past suicidal behaviour is related to being neglected as a child. He feels that he doesn't belong and is a burden to other people. He finds it difficult to express himself emotionally and consequently does not form friendships easily. One of his primary motives for considering suicide is that "nobody cares. It's best if I just take my life". Below is an extract of the interview to provide an insight into his experience of neglect and lack of emotional support:

> I grew up feeling isolated … I grew up within a large family, like there were a lot of children and I was like the quietest of them all (…) So I was just quiet, even if I was hungry I just keep quiet. And then sometimes if I didn't want to eat, they would just hit me and punish me harshly, you know, just for not wanting to eat. So when I grew up I disliked all my family members, all my relatives, including my mother, you know. … So let me say, I don't have that person to tell me: "Themba [pseudonym], here you did well, keep it up" and someone say: "Thank you for what you did for me". Like I try my best but no one would get satisfied.

Participant 3's description of how his unfulfilled need for belonging lead him to become suicidal links strongly with the psychodynamic theory by Buie and Maltberger (1983), who propose that suicidality arises from overwhelming negative self-judgment and an intense and intolerable experience of aloneness. Buie and Maltberger's (1983) description of aloneness expresses well the intensity of emotion participant 3 communicated in the interview:

> [Aloneness is] a subjective state of vacant, cold isolation without hope of comfort from within or without; it is accompanied by varying degrees of fear and horror that may amount to terror. It may be felt in lesser degrees as an agitating sense of disquiet, but essentially it is akin to the panic of the screaming infant overwhelmed with separation anxiety. It involves to some degree the sense of dying. (p. 60)

6.3.4.2. Negative peer interactions. Several participants point out that one of the main interpersonal causes for suicidal behaviour amongst young men are peer pressure and bullying, since these negatively affect a person's self-worth and may lead them to develop a sense of thwarted belongingness, which is a risk for suicidal behaviour, according to Joiner (2005). Moreover, several previous quantitative (see Hinduja, S. & Patchin, 2010) and

qualitative (Cleary, 2005) studies have indicated that peer pressure and bullying is an important risk factor for suicidal behaviour amongst young men.

Furthermore, participant 8 gives an interesting account of how peer group dynamics in early adolescence can lead to the expression of suicidal behaviour. He describes how his friendship group at school shared a common goal: to find out what it means to die. He explains how this led to all the group members practicing deliberate self-harm without intent to die. Beyond that, it also caused him to attempt suicide and precipitated the suicide of his best friend.

> Well, first of all we always spoke about it, it was like I said that "I wonder how it feels, I wonder if earth itself isn't hell". So we were your sort of typical rockers. So we were very like to the dark phase of life and stuff. So we were very much intrigued by death and we'd go to the graveyard and sit there. We spoke about it a lot, but you know when you just talk about it but you are very unsure whether you should do this and you are afraid but you never want to show that to you friends because you wanna be superior.

Participant 8 account ties in with research on suicidal subcultures by Lester (1989), who posits that during adolescence experimentation and competition amongst peers may lead to the development of suicidal subcultures (characterised by substance abuse problems, poor relationships with parents, poor self-image, dependency on peers, loss of lovers and a deep involvement in heavy metal rock music), which may prompt cluster suicides.

6.3.5. Illness. Severe and incurable physical illness is considered by all participants to be an important cause for suicidal behaviour. Moreover, three mental disorders, depression, bipolar disorder and schizophrenia, are believed to be implicated in suicidal behaviour. However, depression is not seen as predominant cause of suicidal behaviour, primarily because it is believed to be treatable. It should be noted that when referring to "being

depressed" participants mostly refer to an emotional state, rather than a condition. Some participants also used the term "emo", which means having a depressed mood and being isolated from others.

Kral (1998) posits that depression is merely one risk factor of suicidal behaviour and it alone does not directly address the experience of suicidality. Participants may also distance themselves from a discourse of depression because it is 'incompatibile' with dominant masculinity ideologies (Addis & Mahalik, 2003). According to Courtney (2000), "denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower-status position relative to women and other men" (p. 139). Finally, it can also be argued that male depression may be expressed differently than stipulated by the *Diagnostic Statistical Manual* and that this may explain why participants describe the suicidal state in terms of anger and lack of control, rather than in terms of depressive mood. Similar to the present study, Cleary (2005) found that that not depression, but a sense of anger and powerlessness and aimlessness were the predominant emotions that young males with a history of suicide attempts referred to with regard to their suicidal behaviour.

6.3.6. Impaired cognitive functioning. An altered mental state is cited as one of the main causes for suicidal behaviour. This includes a pessimistic view of the future ("they got nothing to look forward to") as well as perceiving obstacles as unbearable and subsequently taking on a defeatist attitude. For example, participant 12 says: "when their [suicidal individuals] problems have gotten bigger than any sort of possible solution that they could foresee or that they could imagine. So for them the only way out is death, not be around to deal with it anymore". All participants mention that a narrow focus on only one aspect of life may lead people to see no alternatives. Participant 12 describes this cognitive rigidity in the extract below:

> I think when you are that deep in distress that you wanna commit suicide, a lot of times you also have blinders on. You are just focusing on the thing that is making you stressed. You don't look for other ways that could possibly lead to something better, so that could be a big one. I think they just don't know that is really exists.

Other cognitive distortions cited by participants are a perceived lack of social support, lack of adaptive cognitive coping skills and perceiving oneself to be different and therefore not accepted by others. For example, participant 2 shares that he attempted suicide because he felt that he is not accepted by others or even God for being homosexual and having red hair. He says: "So many times I thought I hate myself, you know. Cos what is this? Not even God will accept me."

All the cognitive distortions mentioned above are also identified by previous quantitative cognitive and attitude research as the main cognitive distortions that precede suicidal behaviour (for example, Knizek et al., 2010, 2011; Schotte & Clum, 1987; Wenzel & Beck, 2008; Williams & Pollock, 2001).

6.3.7. Altered emotional state. Besides cognitive "blinders", intense or overwhelming emotions and an inability to regulate emotions is believed to be the most proximal cause for suicidal behaviour by participants of the present study. Feeling isolated, ashamed and angry are the core emotional states that participants causally relate to suicidal behaviour:

6.3.7.1. Feeling isolated. Feeling isolated is repeatedly described to be associated with suicidal behaviour. The extracts below underscore the state of isolation that may precede suicidal behaviour:

> So I feel the problem is that there is a sense of complete isolation. So I think why somebody would follow through is that there is an immense sense of cut-off from

> your reality. It's not that you are living in a non-reality or in a version that isn't real; it's just that your support doesn't seem accessible to you. (Participant 4)
>
> …when I started having my fall out I clammed up, that was definitely a characteristic thing. You clam up because you don't feel like talking about things, you don't feel like divulging your own emotions, you're scared to somehow release them or whatever. So you completely isolate yourself from the world. You don't speak to you anyone, you just stay at home. (Participant 9)

6.3.7.2. Shame. Shame is defined by participants as not meeting their own, their parents' or broader cultural expectations. Academic failure and the shame resulting thereof is reported by many participants as a reason for them and others to engage in suicidal behaviour. For example, participant 9 says:" So accepting that shame that you have disappointed someone you love – that is like painstakingly hard. You really would, I would do anything else, especially at the time." and participant 5 says: " (…) he committed suicide after he failed grade 11 (…) I'm thinking you know that the embarrassment – I've heard a lot of people saying they can't live with the humiliation."

According to Rochat (2011), shame is the primary emotion of self-consciousness – the experience of self in relation to others. If suicide is an escape of *self-consciousness* as Baumeister (1990) proposes, then it makes sense that participants highlight shame as one of the prominent emotions involved in suicidal behaviour. In African studies on attitudes towards suicide shame holds a central position (Hjelmeland, Akotia et al., 2008; Hjelmeland, Knizek et al., 2008), possibly since shame is a more powerful emotion in interdependent than independent cultures (Draguns & Tanaka-Matsumi, 2003). In a recent study by Adinkrah (2012), it was found that men engaged in suicide to escape shame and dishonour of different sources, such as criminal prosecution and sexual impotence. In the present study the wish to

escape shame by suicide was mentioned by participants across racial and cultural divisions in response to academic failure, possibly because as university students it is a central concern.

6.3.7.3. Anger. While female suicidal behaviour is understood by participants to be an expression of sadness in response to relationship difficulties, male suicidal behaviour is believed to be an expression of anger. For example, participant 12 says:

> I think that a lot of times, especially with young men it is anger, their suicide is anger-based. Anger at life, anger at a lot of things. (…) women tend to do it out of sadness or a broken heart, whereas men do it out of anger or rage. It is like when a man gets emotionally hurt, he gets angry. It is like a stigma thing, and I think most people do and I think that why men use more violent methods is that it reflects what they feel on the inside, I just cut my wrists, I just put a bullet to my head kind of thing.

Participants explain that continuously suppressing one's emotions leads to a build-up of anger and aggression, which may cause men to engage in suicidal behaviour in a more violent way. Participant 10 says:

> You know, when you are sad you must cry to feel better about it. Being angry about it and getting over it in a few days doesn't help, because that feeling is still there. You might think that you are ok and someone is gonna make you angry and put that in the same place where you have everything else and then you're gonna lash out. (…) You know it becomes killing.

Furthermore participant 9 argues that by making it less acceptable for boys and young men these days to have "anger outbursts", they cannot develop effective emotional regulation strategies. Participant 9 shares that he found it difficult to control his temper near the time of attempting suicide:

> (…) the smallest things would agitate me. You know I typically don't have like a temper problem at all, but during that time somebody would talk to me and look at me wrong and I would just get agitated and wanted to rip their heads off.

Finally, anger is also described to be the underlying cause for both homicide and suicide. In his account of his best friend's suicide, participant 8 states: "I believe that he would have hurt someone at the end of the day, because he felt so like angry at everything".

Participants' reference to anger and aggression as central emotions in suicidal behaviour supports both Freud's (1917/1957) theory that suicide is an inward turned aggression against an internalised object of love and hate and Menninger's (1938) theory that suicide is a wish to kill, a wish to be killed and a wish to die. Moreover, the findings confirm Henry and Short's (1954) hypothesis that homicide and suicide are two sides of the same coin. According to Henry and Short (1954), people's choice to engage in suicide or homicide depends on whether blame is directed at self in the presence of weak external constraints (suicide) or blame is directed at others in the presence of strong external restraints (homicide).

From the findings relating to the theme 'Perceived causes and risk factors of suicidal behaviour', it can be gleaned that reference to psychopathology as a cause for suicidal behaviour is conspicuously absent. Instead, suicidal behaviour is perceived by participants to be caused by social and cognitive-emotional factors that dynamically interact with each other. While psychopathology as a cause of suicidal behaviour is a dominant theme in the majority of studies in the suicidology literature, recent studies that focused on men's views (Cleary, 2005; Cleary, 2012) and young people's views on suicidal behaviour (Roen et al., 2008) confirm the present studies finding that causes are understood in psycho-social, rather than in psychopathology terms by young men. Despite the focus on mental illness in the suicidology literature, the present studies result indicates that it may not always be helpful to understand

suicidal behaviour through a psychiatric lens when trying to understand young men's suicidal behaviour. According to Roen et al. (2008), "If we were to step away from a mental-health frame of understanding, and approach suicide as a psycho-social phenomenon that occurs within cultural contexts and impacts on whole communities, we might be in a better position to understand how suicidal possibilities appear to young people." (p.2090)

6.4. Theme 3: Perceived motives

A motive is the reason for an individual to engage in the suicidal behaviour (Hjelmeland & Knizek, 1999). In the present study a common perceived motive for engaging in suicidal behaviour is an *escape-oriented motive* - a desire to escape from an unbearable situation, state of mind or intense and overwhelming emotional state. Participant 2 views suicide as a means to escape a state of mind, which he coins "macid", meaning "all the thoughts coming in at one moment and its craziness". Moreover, participant 9 provides a detailed account of how his suicide attempt was driven by a fervent wish to escape from a situation of failing to juggle all his commitments and regain control. He compares his path leading to suicide to a seed, which started to grow when he first "escaped" an exam by leaving the exam venue and peaked when he tried to "escape" his life.

> I think it is more the emotions, the pressure and the stress that you feel … that you think to yourself "I can't handle it. I just want it to go away". I'll do anything to let it go away. I mean obviously the seed was planted … the seed was planted when I've decided that just walking away from my exam made it go away. It didn't obviously, but it was that feeling - just all of a sudden the stress is gone. (…) the same seed obviously just grew and I thought "Well, what if I just disappear, then it all goes away. (Participant 9)

The need to escape from life is associated with a feeling of being "trapped", "stuck in a rut", "suffocated" and pressured. An account by participant 8 illustrates this:

> Growing up in a house where rules are rules, you know there is no going back and forth, it's just rules and being in the house felt like you are being suffocated, it felt like you are being watched … that is why I felt trapped. I couldn't express myself.

The idea of escape from perceived entrapment ("arrested flight") is in line with William's (1997) model of suicidal behaviour , according to which suicide is "cry of pain "to an individual feeling defeated and trapped by their current life situation and perceiving no rescue or other escape. Baumeister (1990) also suggests that suicide is an escape, but an escape from painful self-awareness. Wishing to cease self-awareness or "to sleep", rather than death per se, is a common theme in the interviews, especially amongst participants with a history of suicidal behaviour. The extracts below illustrate the wish to escape from self-awareness:

> I think it is more of the emotions, the pressure and the stress that you feel … that you think to yourself I can't handle it, I just want it to go away. I'll do anything to let it go away. (Participant 8)

> (…) to understand suicide I realised that it is not that one would pursue death, you don't get to a point. No one pursues death. For some strange reason the will to live is greater than the will to die. And when you have those thoughts, the will to live is greater, it really is.… It's not that I want to die, it's just that you want to be able to just switch off and if you weren't to wake up again it's ok. (Participant 4)

Moreover, *interpersonal motives* are also mentioned by most participants, including communicating emotions to others, wishing to hurt others and seeking attention or sympathy from others. For participant 2 these motives are central to his suicidal behaviour. He says:

> I needed attention because nobody saw my pain, probably also because of my shame. I wanted somebody to see my pain. I don't know who. I probably wanted everyone to

> see, especially all my friends probably. My parents, kind of, I just wanted to hide it from them.

Most participants viewed suicidal behaviour to have a communicative function, which reflects Shneidman (1996) and Knizek and Hjelmeland's (2007) view that suicide is an act of communication in an extreme situation, in which verbal communication is thought to be inadequate or inappropriate. Knizek and Hjelmeland (2007) have recently proposed an interpretive model (suicidal behaviour as communication), which utilises discourse, hermeneutic, conversation analysis as well as socio-semiotics to establish a typology that can be used for a more goal directed treatment of the suicidal patient and prevention of suicidal behaviour.

Moreover, *existentialist motive* of ending a perceived meaningless existence ("having no reason for living") features prominently in interviews, especially in interviews of participants with past suicidal ideation. Interestingly, several participants report that their wish to die paradoxically reaffirmed their will for living. For example, participant 10 describes his suicidal ideation as a "wake-up call" to change his life and Participant 5 shares:

> After two wrecked cars nothing happened to me. I don't know, it is just coincidence perhaps, but those kind of factors were enforcing to just kind of give you meaning and feel like there is something bigger.

The idea that through confronting death a new life can begin is in line with the Jungian conceptualisation that suicide may symbolise a wish to be "reborn" by suicidal individuals (Berman & Jobes, 1991). According to this view, the suicidal individual tries to overcomes his/her frustrations by regressing towards a new-born self.

Finally, *identity motives* are cited as a reason by three participants. Some participants describe that they wished to commit suicide because they were curious to find out what it

means to "be" dead, which is paradoxical considering that "being" is possibly annihilated by suicide. Participants 5 and 12 refer to such paradoxical identity motives:

> Obviously teenagers are gonna talk about it, always pushing the boundaries, being a bit rebellious, you know. You see it as something that's exciting, but something that definitely got a taboo to it. And anything that is generally a taboo, people are generally very interested by it. (Participant 12)
>
> I was so curious what it would be like doing it [suicide] … Ja, it was just curiosity … I've never been too overwhelmed by my circumstances and wanting to find a way out.(Participant 5)

The above extracts tie in with Erikson (1968) theory that suicide may become an identity choice for some adolescents in the face of developmental and environmental stressors and support the argument that suicidal adolescents often do not consider the consequences of their actions due to their tendency of an egocentric mind-set (Portes et al., 2002).

In summary, participants identified four motives for engaging in suicidal behaviour: escape-oriented, interpersonal, existentialist and identity motives. These motives have also been identified as core motives for suicidal behaviour by previous research (e.g. Michel, Valach, & Waeber, 1994; Skogman & Öjehagen, 2003).

6.5. Perceived prevention and protective factors of suicidal behaviour

All participants believe that suicide can be prevented. Some participants believe that suicidality is communicated by certain verbal and non-verbal cues (for example isolation from others and engaging in self-destructive behaviours, such as alcohol and drug abuse and self-mutilation). However, other participants believe that "those that do it don't actually speak about it", and that suicide is an impulsive act and is thus quite difficult to prevent. Furthermore, participant 1 contends that in order to prevent suicide it is better not to talk about suicide directly, because this may evoke suicidal thoughts in people. He says:

> I'd rather speak about it with higher people and try and find solutions as opposed to speaking about it with first years coming in and creating this whole uninformed conversation, which they will just put at the back of their minds.

A number of strategies and factors are believed to prevent people from engaging in suicidal behaviour according to participants:

6.5.1. Religious involvement. In line with Osafo, Knizek et al. (2011) and Domino (2005), feeling a sense of connectedness with a higher deity is described to be protective against suicide by participants. Participant 3 says:

> I have this notion of saying people won't get satisfied. Either way, if you do right or wrong, they don't get satisfied. So what I'm gonna do is, I'm gonna do what really satisfies God, you know. I don't think now I'd commit suicide because it is against God.

Four participants report that going to church regularly and praying helps to gain renewed hope and motivation for life, which is in accord with Knizek et al. (2010) and Osafo, Knizek et al. (2011a). Many participants also draw attention to the religious sanctions against suicide by their own or other churches and how these may deter people from engaging in suicidal behaviour. Participant 12 says:

> I think that South Africa is predominantly a religious country. You always hear the priest saying when you commit suicide you go to hell. So mainly this stigma of "suicide equals hell". So I think if you are from deeply religious family … if someone commits suicide, a lot of times that person could be disowned or people would say he wasn't a "godly" person (…)

6.5.2. Get social. To counter cognitive rigidity and isolation associated with suicidal behaviour, all participants promote becoming more socially engaged, for example going out with friends or taking part in student groups, such sports groups or residence activities.

Participant 2 says "just surround yourself with people cos people carry people" and cites the bible to support his point: "I read in proverbs where Solomon says that it is not good being in solitude or something because the opinions and ideas of other people should get into your mind as well, not only your own thoughts."

Another avenue for social interaction is the social media. Participant 2 mentions that social media, such as facebook, Mxit and mig33, has helped him to get attention and support from people in difficult times. He argues that the advantage of chatting is that "you can just release it all and the person won't be there to judge you and even if they do it is not hurting that much because it is only letters on a screen". Furthermore, he says:

> P: And you know what really works is your status on Facebook. I would always post a status on facebook or something on there.
>
> I: And do people respond to it?
>
> P: Yes and I like the attention I get there as well.

6.5.3. Close relationships are key. Participant 4 says: "I think if one were to expect change or see change one would have to see it in attempts to address how people actually engage in their relationships". Participant 8 and 2 echo this idea. They describe that intimate interpersonal relationships helped them to make peace with themselves and stopped them being suicidal and self-destructive. Participant 8 says:

> Since I have met my partner I haven't touched a blade once (…) but also like people started believing in me and actually seeing who I really am, not just the emo kid (…). People start seeing me as a person with feelings. Ja, that is why I stopped. I don't have tendencies any longer.

Many participants also suggest that the only way to reach out to men in distress is to work through women that they have intimate relationships with, such as mothers, girlfriends and wives. For example, participant 9 says:

> Guys don't listen to guys. If a guy tells them something they would just be like "screw you". Guys listen to women they love, whether it'll be wives or girlfriends. That will be where your input is.

6.5.4. Formal interventions. In terms of formal interventions, school-based suicide awareness programmes, free counselling at schools, life skills programmes for young people, suicide hotline awareness initiatives, and support groups for suicidal individuals are suggested by almost all participants. Participants point out that interventions need to especially focus on addressing men's stigma to seeking informal and formal support. Participant 9 says:

> I would say you can't just treat the symptom of guys that if they have stress they must talk about it. You can't treat the symptom; you must treat the root of it. And the root of it is that guys feel unable to externalise their emotions. (…) It will always be a stigma, it always existed, trying to change that will take more than just a few generations of work.

Furthermore, participant 3 proposes that more needs to be done with regard to community development, such as building sports facilities and youth centres, where young people can interact in positive ways and learn to take charge of their life.

Finally, many participants call for more cultural and sexual diversity awareness initiatives in order to create a more unified society that is supportive of young people's identity development. Interestingly, two participants mention how during the soccer world cup in South Africa in 2010 such a national unity and strong sense of belongingness was achieved. Joiner, Hollar, and Van Orden (2006) call this the "pulling together" effect. In their research they found that national sports events and crises produce an increased sense of belongingness and decreased occurrences of suicidal behaviour.

6.5.5. Mind work. Finally, participants reiterate the idea that suicide is a choice and that suicide can be prevented if one revaluates one's attitude and makes a conscious decision

to overcome rather than escape obstacles. For example, participant 2 conveys how life and death hinges on choice:

> Yes, like many times I was in deep depression and I would be like in my room, my door closed and everything is dark, I would just sit there …then I would just think about everything and how I would die and could die and who will miss me and all of that. So I kinda had this self-pity and then I realised many times it's just that single moment of choice. I just got to choose to open my window, put on the light, make up my bed and just play with my dogs for a couple of moments and then I feel better.

Furthermore, participant 6 says that he learned to cope with difficult situations by "breaking down, not building up issues, but rather taking them apart and sorting out one issue at the time." He also believes that what helped him to get through his suicidal ideation is the belief that "you can't change everything in the world but there is something you can always change and that is your attitude". Many other participants advocate for a change in attitude – an attitude that "life is a gift" and that "there is always someone who is in a worse state than you". Some participants believe that psychologists are instrumental in helping suicidal individuals to change their perspective on life and death and to accept certain life situations that cause them psychological distress.

In summary of this theme, all participants believe that suicidal behaviour can be prevented, which is in line with previous studies (for e.g. Hjelmeland & Knizek, 2004; Knizek et al., 2011, 2010). Most participants focused on prevention at the intrapersonal and interpersonal level, which is contrary to Knizek et al. (2011, 2010) who found that participants focused on the societal level mostly. The results of the present study suggest that participants understand suicidal individuals to be agents of their own behaviour, rather than subjects of their external circumstances.

6.6. Conclusion

Participants' attitudes regarding the moral acceptability of suicidal behaviour are ambiguous. Participants endorse a permissive attitude towards suicidal behaviour by drawing on the ethical argument of right to life, but at the same time advocate a non-permissive attitude towards suicide by bringing into play interpersonal and religious ethical arguments. There is thus a tension between perceiving the suicidal individual as a rational autonomous versus as a relational agent. Many participants try to relieve this tension by arguing for an acceptance of suicidal behaviour under certain circumstance, but not others.

In terms of causes and risk factors, participants understand suicidal behaviour to be a psychosocial phenomenon that occurs in the individual's specific interpersonal, social, cultural and economic context, rather than a primarily individual phenomenon that resides in psychopathology. The performance of male suicidal behaviour is also construed as being intricately connected to ideas and practices that are in alignment with hegemonic masculinity. Moreover, being homosexual in a homophobic context, having no close and supportive relationships and being involved in negative interpersonal interactions, such as peer pressure and bullying, are all considered to increase vulnerability for suicidal behaviour.

On an intrapersonal level, severe and incurable physical illness is considered a prominent and acceptable cause for male suicidal behaviour, whereas mental illness (except mental illness with psychotic symptomology) is regarded to be treatable and is therefore not generally accepted as a reason for suicidal behaviour. However, cognitive distortions are commonly mentioned by participants to lead people to perceive suicide as the only way out. In addition, experiencing intense and overwhelming emotions, including isolation, shame and anger, is construed by participants to prompt people to want to "escape" from life.

The common motives mentioned for suicidal behaviour is to escape unbearable circumstances or psychological pain, interpersonal motives, existential motives and identity

motives. It is important to note that participants believe that having the wish to engage in suicidal behaviour, does not necessarily mean wanting to die.

Finally, participants believe that suicidal behaviour can be prevented and regard religious involvement, relationship building, school-based interventions, community development and developing better cognitive coping mechanisms as the main avenues for suicide prevention.

CHAPTER 7: RESEARCH FINDINGS AND DISCUSSION: PART II

7.1. Introduction

The attitudes, beliefs and myths about suicidal behaviour expressed by participants of the present study are coloured by two underlying narratives: (1) thwarted belonging; and (2) hegemonic masculinity. These narratives are discussed in this chapter under the headings 'Apart or a part: Belonging and suicidal behaviour' and 'Dying to be a man: (Re) negotiating masculinity'. The discussion of these two underlying narratives is presented in relation to the literature and previous research findings. Moreover, implications of the research findings for future research on suicidal behaviour are considered.

7.2. Apart or a part: Belonging and suicidal behaviour

In the present study participants understand and judge suicidal behaviour in terms of belonging. Belonging refers to "a sense of personal involvement in a social system so that persons feel themselves to be an indispensable and integral part of the system" (Anant, 1966, p. 21, as cited in Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). In this section a brief overview of research findings relating to the theme of 'Apart or a part: Belonging and suicidal behaviour' is presented, which is followed by a discussion of research findings and recommendations for future research.

7.2.1. Overview of research findings. What gives life meaning? Participants of the present study state that they believe that belonging to a relational network (including family, friends and higher deity) endows life with meaning, but that the absence of supportive and caring relationships renders life meaningless.

Suicidal behaviour is also understood by participants to result from a state of *being apart* – being socially disconnected and/or feeling isolated from close others, God, and broader social context. In contrast, protection against suicidal behaviour is thought to be

offered by a state of *being a part*, which is characterised by strong social ties and feeling accepted by close others, God, and the broader social context.

Moral acceptability of suicidal behaviour is also judged on the basis of belonging. While suicidal behaviour is considered unacceptable if an individual belongs to a relational network (including family, friends, and higher deity), it is deemed understandable if an individual does not form a part of such a relational network. Participants articulate that belonging to a relational network means having certain roles and responsibilities and that it is selfish to evade these roles and responsibilities by taking one's own life.

Moreover, sense of belonging in interpersonal relationships takes centre stage in participants' description of motives of suicidal behaviour. Participants affirm several interpersonal motives, including wishing to communicate distress, seeking attention and sympathy and wanting to hurt and manipulate others, and thereby signify that suicidal behaviour is a relational, rather than an explicitly individual behaviour.

Finally, in terms of prevention, participants emphasise increasing social connectedness, strengthening intimate relationships and community development initiatives. All these prevention strategies centre on building social connectivity, such that people's need to belong is met.

7.2.2. Discussion of research findings. Belonging is not a novel concept. A number of theorists have proposed that humans are foremost relational beings and that human motivation is guided by the formation and maintenance of social bonds. For example, Maslow (1954) considered belonging to be a core human need, Bowlby (1969) emphasised the need to form and maintain secure relationships, and Winnicot (1987) said: "If you set out to describe a baby you will find that you are describing a *baby and someone*. A baby cannot exist alone, but is essentially part of a relationship" (as cited in Mokros, 1995, p.1094). More recently, Baumeister and Leary (1995) reviewed empirical research on the belonging and

concluded that human beings are "fundamentally and pervasively motivated by a need to belong" (p.522). According to Baumeister and Leary (1995), belonging entails "a combination of frequent interaction and persistent care" (p.497) and they propose that the absence of either of the two leads an individual to experience "partial deprivation" (p.513).

Several psychological and sociological theories in the field of suicidology also emphasise the role of belonging in suicidal behaviour. For example, Durkheim (1897/1951) suggests that the lack of social integration motivates a person to end their life and Shneidman (1993) views the suicidal individuals "psycheache" to result from frustrated psychological needs, including the need for love, acceptance and belonging. Most recently, Joiner (2005) proposed that thwarted belongingness and a perception of burdensomeness contribute to the desire to engage in suicidal behaviour in his interpersonal model of suicidal behaviour. In confirmation of these theories, various quantitative studies have found social isolation to be a strong predictor of suicidal ideation, suicide attempts and fatal suicidal behaviour (for example, Joiner & Van Orden, 2008).

Besides studies investigating statistical associations between indicators of social connectedness and suicidal behaviour at the individual and population level, there has been little regard for understanding the "experience-near" interaction between the suicidal individual and his/her surrounding (Mokros, 1995). Mokros (1995) argues that in the suicidology literature the understanding of suicidal behaviour as relational is hampered by what he calls the "micro/macro problem":

On the one hand suicidal behaviour is understood in psychological terms, focusing on how individual factors lead a person to suicide (micro perspective). For example, Shneidman (1996) views "each suicidal drama occurs in the *mind* of a unique individual" (p.5) and currently suicidal behaviour is commonly portrayed as a symptom of psychopathology in the suicidology literature.

On the other hand, suicidal behaviour is understood in sociological terms, focusing on how social forces cast 'vulnerable' individuals adrift (macro perspective). For example, Durkheim (1897/1951) views suicide as a symptom of social dysfunction. He writes that the suicidal individuals' "sadness comes to him from *without*" (p. 10).

In the words of Leenaars (2002b), "[s]uicidology has always been committed to understanding the suicide in general [nomothetic research] and the suicide in particular [ideographic clinical focus]" (p. 1). However, there has been little emphasis on understanding suicide in the "in-between" – the intersection between the individual and his/her surrounding, or what Goffman (1983) calls the "interaction order".

Participants of the present study situate suicidal behaviour in this "interaction order" by drawing on a narrative of belonging and thereby locate suicidal behaviour in the dynamic relationship between the individual and his/her context. This portrayal of suicidal behaviour contradicts macro and micro conceptualisations of suicide, which depict the suicidal individual as a *discrete individual entity*, *driven* to engage in suicidal behaviour by a disembodied mind or social factors. In contrast, participants of the present study understand the suicidal self as *relational* and represent suicidal behaviour as *mutually co-established* between the self and the context in which it is embedded.

Admittedly, it serves to view the suicidal individual as a discrete individual entity or single unit of analysis when setting out to conduct quantitative research. However, it is questionable whether the Western psychological and psychiatric understanding of suicidal behaviour as individual and measurable is truly a reflection of the relational nature of suicidal behaviour.

While it is valuable to establish risk factors for suicidal behaviour that are statistically significant in individual and population terms, this alone is not enough. When targeting risk factors of suicidal behaviour for purposes of prevention it is crucial to understand what the

target populations' views are on suicidal behaviour and its prevention. According to Vijayakumar et al. (2005) "the intervention is unlikely to succeed unless the community finds it acceptable for it to be addressed, and agrees with the thrust of the intervention" (p.121). For example, despite the emphasis on mental illness as a risk factor in the suicidology literature, participants of the present study understand suicidal behaviour in psychosocial terms rather than psychopathological terms. It may thus be more appropriate for prevention programmes targeting young men to focus on psychosocial, rather than psychiatric understandings of suicidal behaviour.

7.2.3. Recommendation for future research. To date, comparatively few qualitative studies investigating at-risk populations' views of suicidal behaviour have been conducted (Cleary, 2012, Cleary, 2005; Roen et al., 2008). Similar to the present study, studies conducted with male participants (Cleary, 2012; Cleary; 2005) have shown that participants view suicidal behaviour to arise from a dynamic and reciprocal interaction between individual and contextual factors. Future qualitative research with populations at-risk for suicidal behaviour can contribute to a better understanding of the relational or "in-between" nature of suicidal behaviour, on which theoretical conceptualisations and prevention models of suicidal behaviour may be built.

7.3. Dying to be a man: (Re) negotiating masculinity

The present theme is concerned with participants understanding and evaluation of suicidal behaviour in terms of men's relational position to hegemonic masculinity. Hegemonic masculinity is the most desired or honoured version of masculinity, according to Connell (1995). In the present study hegemonic masculinity is associated with being heterosexual, employed, academically successful and possessing traits such as control, physical strength, rationality, emotional restraint, competitiveness, courage, independence, and dominance over women. This section provides a description and discussion of how

participants frame men's pursuit of hegemonic masculinity as being problematic with regard to suicidal behaviour and how participants consider their own relational position to hegemonic masculinity to be protective against suicidal behaviour. In closing, recommendations for future research are described.

7.3.1. Overview of research findings. All participants assert that men are inclined to engage in suicidal behaviour in two instances: (1) when they fail to live up to the standards of hegemonic masculinity (for example, being unemployed, homosexual, and unsuccessful) or (2) when they strongly conform to the hegemonic masculinity ideal and engage in "toxic practices", such as alcohol and drug use, violence, aggression, and risk-taking behaviour, instead of "feminine" practices, such as seeking help and sharing their emotional distress with others.

If hegemonic masculinity compromises men's well-being, why then do men conform to it? Participants explain that men feel pressured to act "manly" by other men who police their behaviour (especially fathers and peers) and women who prescribe that men should have a particular masculine image. For example participant 13 says:

> I think men need to live to a standard cos if you are a man you must be manly, you must be strong, you must be … cos if you are not strong, if you are weak and if you're soft, you're automatically like not a man. And what are you then? I don't know. (…) I think it [male suicide] has got to do with expectations, like society put expectations on men and women are a lot more flexible with each other as well. So if you are a woman you can conform more to different things and change and reinvent yourself. If you are a man you must be this type of man and you must in whatever community you are now (…).

As the extract above conveys, men (unlike women) are believed to have limited options in terms of identity. Being a "real man" is regarded by participants to be the only

reputable identity option men have, because other gender identities, such as being homosexual or feminine, are believed to be subordinate to hegemonic masculinity. Participant 10 says that as a man you are either "macho or idiot". Even homosexual participants who reject hegemonic masculinity say that they feel compelled to be emotionally detached and reluctant to seek help, especially in the company of other men.

Participants articulate that not acting in accordance with the dominant masculine ideal means risking being ostracised by others. Moreover, they associate failure to live up to hegemonic masculinity with shame. According to Rochat (2011), shame is the "avoidant behavioural expression of being exposed to public scrutiny" or in other words, "the pain of being seen" (p.113). Shame that is unacknowledged, according to Scheff (1994), leads to anger and withdrawal (McDermont, Roen, & Scourfield, 2008). Shame, anger and feeling isolated are also believed by the young men in this study to be to be the core emotions preceding male suicidal behaviour. Participants explain that men engage in suicidal behaviour in order to escape from this self-conscious state of shame-anger-isolation, which is in line with the escape theory of Baumeister (1990) and Shneidman (1996).

Besides participants' explanation of how "doing masculinity" is linked to "doing suicidal behaviour", it is valuable to examine how participants make sense of their *own* engagement or non-engagement in suicidal behaviour through a lens of masculinity:

Although all participants conform to a hegemonic type of masculinity, there is a good deal of flexibility in their compliance. Participants suggest that flexibility in their compliance to hegemonic masculinity protects them from engaging in suicidal behaviour. What follows is a brief overview of how the different groups of participants - without a history of suicidal behaviour, with a history of suicidal ideation and with a history of a suicide attempt - understand their suicidal behaviour in relation to their own masculine identity.

Two of the four participants with no reported history of suicidal behaviour strongly align themselves with hegemonic masculinity ideals of being independent, rational and capable of solving their own problems and suggest that these characteristics protect them from engaging in suicidal behaviour. The other two participants with no reported history of suicidal behaviour affirm that they comply with hegemonic masculinity, but resist some hegemonic masculinity practices, such as emotional non-disclosure and help negation, for the sake of their psychological wellbeing. For example, participant 1 says:

> I mean in certain aspects I am masculine. I mean I play rugby, I've got male friends, I'm attracted to females. So yes, in that context I am masculine, but in another sense I am able to be in touch with my emotions and I have traits that aren't the typical stigmatised masculine traits.

Moreover, participants with previous suicidal ideation describe how they experienced a suicidal crisis, but that they conquered their crisis by aligning themselves with masculine ideals of strength, rationality and being in control. For example, participant 3 says:

> (…) and then it came to me that no, this is not the right thing to do. You meant to face your problems (…) So I need to pick up my socks and work hard for what I believe in. That's how I motivate myself, it's like if I fail at least I've tried. So everything I think of, if I want something like a job maybe I just go out and look for it. That's how I keep my motivation, my self-motivation that I must take charge of my life.

Finally, participants with a previous suicide attempt explain how their conformity to hegemonic practices contributed to them attempting suicide, but that their suicidal experience has led them to challenge some of the dominant masculinity ideals. For example, participants 8 and 9 say:

> I think back to December last year , if you told me that I'd go to a psychiatrist I would say those are just a bunch of pricks, I will never go and they are just stealing our

> money and they are useless. I would have said something like that cos I never thought talking about your issues were useful. So if you talk to a guy that is not having issues now, he will just think that you are an idiot. (Participant 8)
>
> So I actually come more in contact with my emotions. I realise that it actually helps to cry sometimes, it is really not a big thing. Cos once again I come from a home where you have your gender roles, men don't cry and my dad didn't show that he is sad , my brothers as well. You can see it in them, so obviously I adapted those ways of doing things. (Participant 9)

Taken together, participants of the present study do not strictly align themselves with hegemonic masculinity, but they nonetheless see it as the "gold standard" that most men compare themselves against. Participants propose that suicidal behaviour may arise in this, often tense, relational juncture between the individual man and hegemonic masculinity. Yet, the association they make between masculinity and suicidal behaviour does not imply essentialism. Participants say that being flexible in their compliance to hegemonic masculinity - conforming only to some hegemonic masculinity practices and resisting others - helped them to disengage from their suicidal behaviour.

7.3.2. Discussion of research findings. The present study's findings support Connell's (1995, 2000) theory, which proposes that masculinity is not a consistent concept, but that multiple masculinities are socially constructed in everyday interactions and relate to each other in hierarchies, with hegemonic masculinity being the most desired or honoured version of masculinity. Although Connell's concept of hegemonic masculinities has been criticised for representing men as oversocialised (Whitehead, 2002), the concept has been found to be valuable to explain why men are at higher risk for health-related concerns (Canetto & Cleary, 2012). Much of the previous literature on gender and suicidal behaviour has taken a sex-difference approach to explain the gendered nature of suicidal behaviour (e.g.

Müller-Leimkühler, 2003; Payne, 2008). This sex-difference approach renders invisible the complexity and fluidity of masculinities, because rigid gender differences instead of the inherent reasoning of one gender is the focus of the analysis (Knizek et al., 2011). By employing a qualitative approach, the present study was able to gain an insight into the different ways in which masculinities are expressed and how these expressions may be linked to male suicidal behaviour.

In line with the present study, some qualitative studies on depression and suicidal behaviour (for e.g. Cleary, 2012; Cleary, 2005; Emslie et al., 2006; Oliffe et al., 2011) have found that hegemonic masculinity ideals compel men to deny their emotions and lead them to feel shame when they cannot live up to these ideals. Shame has been pointed out by numerous studies, particularly African studies, to be key precipitant for men engaging in suicidal behaviour (e.g. Adinkrah, 2010; Knizek et al., 2011; Osafo et al., 2011). Qualitative studies with male participants (Cleary, 2012; Emslie et al., 2006; O'Brien et al., 2005) challenge the binary and opposing conceptualisation that men and women differ in terms of emotionality. Similarly the present study found that men lead active emotional lives, but that prevalent masculinity ideals and greater social pressure on men to achieve these ideals may make men more prone to experience shame when they do not measure up to these ideals. Moreover, men have a tendency to suppress their shame, because disclosing their emotions is considered "feminine" or "gay" (Cleary, 2012). Suppressing shame has been linked to anger and withdrawal (Scheff, 1994), both of which have been strongly associated with suicidal behaviour (McDermont et al., 2008). In a few words, gendered scripts of how to behave as a man may influence men's emotional experience and expression and this may consequently put them at a higher risk for suicidal behaviour than women.

Another interesting observation of the present study is that men renegotiate their masculine identity to distance themselves from their desire to engage in suicidal behaviour.

Renegotiating their masculine identity entails resisting 'toxic' hegemonic masculinity practices, including emotional constraint, help negation, alcohol and drug use and risk taking, while conforming to traits such as control and strength that are life affirming. Similar findings have been found by Oliffe et al. (2012) and Emslie et al. (2006). Oliffe et al. (2012) found that depressed men counter their suicidal thoughts by challenging the masculine notion of independence and seeking social connection with others. Male participants in the study by Oliffe et al. (2012) also drew on masculine ideals of strength and control when they talked about depression and suicide, for e.g. "fighting suicidal tendencies". Similarly, Emslie et al. (2006) found that men resist or reconstruct their masculinity in their recovery narratives of depression.

In terms of prevention, the latter findings indicate that it may be worthwhile to specifically address men's relational positions to hegemonic masculinity, the tension these create for them and the maladaptive practices that these encourage. Several authors propose that prevention should promote alternative masculine discourses on emotions and help-seeking, for example reframing help-seeking as taking control and positioning drawing on social support as being rational and responsible (Chandler, 2012; Cleary, 2012; Oliffe et al., 2011). However, Chandler (2012) points out that care should be taken not to reinforce "problematic" aspects of masculine identity or place more demands on men to conform. According to Chandler (2012): "The challenge is how to encourage alternative masculinities without alienating the men one aims to reach, and still communicating in a way that makes sense to them" (p.121).

According to West and Zimmerman (1989) gender is dynamically constructed, produced and reproduced in interaction with others. They posit that ways of "doing gender" form a network that influences how men and women behave. From the present study's interviews it appears that the way men do gender either places them inside or outside society.

In other words, "doing masculinity" in accordance with hegemonic ideals can be seen as a way for the individual man to be accepted as *a part* of a social community of men. However, when performing divergent or subordinate masculinities, such as being homosexual, men put themselves at risk of being socially excluded, which may reinforce feelings of thwarted belongingness and increase their likelihood of engaging in suicidal behaviour.

At a deeper interpretive level, the present study's interviews itself may have involved some degree of gender performance, which needs to be acknowledged. The interviewer in the present study was a female and the interview could have been an opportunity for male participants to perform dominant masculinities. According to Wetherell and Edley (1999), hegemonic norms may be taken up strategically by men in discourse to define a subject position. It is therefore important to adopt interview strategies that take into account performance in interviews with participants (Oliffe & Mroz, 2005). Oliffe & Mroz (2005) share lessons they learned from men interviewing men about health and illness. It may be interesting to similarly investigate gender dynamics between women interviewing men on health-related behaviours.

7.3.3. Recommendations for future research. From the present study's findings it appears that future research needs to focus on how men's relationship with hegemonic masculinity influences their understanding, contemplation or performance of suicidal behaviour. However, the difficulty pertaining to this kind of research is how to investigate the relationship between masculinity and suicidal behaviour without resorting to a gender difference paradigm of masculinity versus femininity, which is simplistically grounded in binary notions of gender as static, fixed, distinct and mutually exclusive constructs..

Jaworski (2010 a) posits that in order to understand how gender is dynamically implicated in suicidal behaviour we first need to understand agency and self in suicide as relational, not as discrete individual. Jaworski (2003, 2010 a) draws on Butlers' writings on

gender as performance to demonstrate that through interpreting suicide as performative, suicidal agency can be reframed as relational.

According to Jaworski (2010 a), suicide can be seen as "doing" because taking a life means performing particular bodily acts to express an outcome. Moreover, Jaworski (2003; 2010) argues that suicide, like gender, is a "reiterative and citational practice by which discourse produces the effect it names" (Butler, 1990, p. 2). In other words, suicide involves a person to repeatedly perform a set of (gendered) norms, bodily acts and gestures (for e.g. thinking about suicide, planning the act, performing the act) and to cite certain established norms, meanings and assumptions within their context (for example, the gender stereotype that completing suicide is masculine, while attempting suicide is feminine) (Jaworski, 2010 a, b). Jaworski (2010 a) writes:

> [Suicidal] authorship is dependent on something other than the individual without the act ceasing to belong to the individual's choice to self-kill. As Butler (2004b, p.16) explains, 'Our acts are not self-generated, but conditioned. We are both at once acted upon and acting, and our 'responsibility' lies in the juncture between the two.'"(p. 681,).

From this perspective, agency and self in suicide can thus be interpreted as relational, according to Jaworski (2010 a), and this makes theorising about how gender comes to reside in the physical act of suicide possible.

Through utilising a perspective of performativity rather than a gender difference paradigm future research may come to better understand how men's construal of their relationship to masculinity may be implicated in suicidal behaviour.

CONCLUSION AND IMPLICATIONS OF RESEARCH FINDINGS

> Suicide. A sideways word, a word that people whisper and mutter and cough: a word that must be squeezed out behind cupped palms or murmured behind closed doors. It was only in dreams that I heard the word shouted, screamed. (Oliver, 2011, p.10)

As the above quote indicates, suicidal behaviour is often portrayed as a private act, which is silenced in public. The present study examined the attitudes, beliefs and myths held by young South African men about suicidal behaviour in order to throw some light on the growing, yet frequently overlooked problem of male suicidal behaviour,

The study found that the group of young men interviewed understood suicidal behaviour not so much as a symptom of mental illness, but (1) as the result of a dynamic interaction between psychological and social factors; (2) as a side-effect of men's pursuit of hegemonic masculinity ideals; and (3) as a relational activity.

These observations are at odds with the dominant psychiatric view which understands suicides as a consequence and symptom of mental illness (Khasakhala et al., 2011). The views of the young men in this study are however echoed in the work of theorists such as Joiner (2005) and Knizek and Hjelmeland (2007), who draw attention to the psychosocial and relational aspects of suicidal behaviour.

Although the study offers a thick description of the beliefs and attitudes of a group of young South African men, the findings need to be treated cautiously. The most notable limitation of the study is the small sample size of thirteen male students from a single University. Given this restriction, the attitudes, beliefs and myths that the participants hold cannot be ascribed to the broad population of young male students in South Africa. The study does, however, suggest that there may be common and shared attitudes, beliefs and myths among young South African men about suicidal behaviour (see Table F1 in Appendix F for a summary of these common attitudes, beliefs and myths). Future studies might seek to

investigate the prevalence and strength of these attitudes, beliefs and myths using empirical methods. For example, a questionnaire based on the findings of the present study and existing attitude towards suicide scales (e.g. the Suicide Opinion Questionnaire (SOQ), and Attitudes Toward Suicide questionnaire (ATTS)) could be used to survey young men across the country (for a review of attitude scales refer to Kodaka, Poštuvan, Inagaki, & Yamada, 2010).

The study is the first to offer an insight into how the target group understands and conceptualises suicide and suicidal behaviour. As such, the study serves as a stepping stone for a more nuanced understanding of the views of young South African men on suicidal behaviour, its causes and its catalysts. It does not purport to be a conclusive effort, but should rather be seen as a tool advancing a more robust dialogue on a topic that is all too often still surrounded by stigma in South African society.

Despite its limitations, the study does provide valuable insights into a phenomenon, which has been widely neglected by South African researchers to date. If the attitudes, beliefs and myths identified by the present study are found to be shared amongst a broader population of young South African men, it will have significant implications for how we communicate with young men about suicidal behaviour, how we package suicide prevention programmes (message and form) and how we engage suicidal men in treatment.

The potentially far-reaching implications of the study are best understood when examined in the context of its three core findings as set out above:

1. Suicidal behaviour as a consequence of dynamic interaction between psychological and social factors

If men understand suicidal behaviour predominantly in psychosocial terms, it means that mental health care professionals may need to set aside their belief that suicidal behaviour is a symptom of psychopathology when engaging with men at risk of suicide and instead understand suicidal behaviour from the worldview of the patient. Greenhalgh and Hurwith

(1999) suggest a narrative approach to enable the patient and the mental health care professional to reach a shared understanding of the patient's suicidal behaviour. From this perspective, the patient is seen as the expert of his own personal experience and is encouraged to share his story with the mental health care professional. Skogman (2006) proposes that the narrative approach be used complementary to diagnosis and treatment of an individual's psychopathology. The advantage of using the narrative approach is that it enables the establishment of a strong therapeutic alliance, which is important for a positive treatment outcome (Michel & Valach, 2001). Moreover, the narrative approach can assist the mental health care professional to determine the diagnosis and treatment, because it provides an insight into the state of mind of the suicidal patient and specific risk factors implicated in the suicidality of the patient (Skogman, 2006).

It can also be argued that young men understand suicidal behaviour in psychosocial terms, because they do not know better. Thus, the argument would run, they need to be educated to view suicidal behaviour as an outcome of mental illness, which needs to be treated by a psychiatrist. Contrarily, it can be argued that stepping away from a mental illness frame of understanding suicidal behaviour may place us in a position of better understanding how and why suicidal behaviour becomes a possibility to young men and to develop prevention strategies that speak to young men.

I argue that the mental illness paradigm represents a formal, top-down approach to treatment at the expense of a more dialogic manner that places emphasis on treatment of the individual. It is not the place of the researcher or mental health care professional to prescribe how a patient has to understand his condition. Rather, the practitioner has to find a way of treating the individual's own understanding of his problem. Changing a patient's understanding of the problem does not necessarily change the underlying problem. It is not viable to disregard how young males frame suicidal behaviour, because it is through this

frame that suicidal behaviour may become a viable option to them. Furthermore, viewing treatment of suicidal behaviour simply as treatment of a mental illness by a psychiatrist negates the patient's own role in the treatment process.

2. Suicidal behaviour in terms of hegemonic models of masculinity

Another prominent finding of this study is that, depending on men's relational position to masculinity, men are believed to be at risk for or protected against engaging in suicidal behaviour. Recent qualitative studies support these findings (e.g. Cleary, 2012; Oliffe et al., 2007). These observations suggest that it may be important to focus on educating mental health care professionals on how men's negotiation of masculine ideals can mediate their experience and expression of suicidality and how gender is construed in the consultation with the patient. Most people visit health care professionals before they engage in suicidal behaviour (Luomo, Martin, & Pearson, 2002; Schlebusch, 2005). However, research indicates that men rarely disclose suicidal ideation to the health professionals (Emslie et al., 2006). If health professionals engage with male patients about the stressors they typically experience as men, it may facilitate them opening up about their distress and help health professionals to get a better indication of the patient's suicide risk. In terms of prevention of male suicidal behaviour, addressing men's relational position to masculinity may be more effective than gender neutral approaches (Oliffe et al., 2007).

It must be noted however, that due to the small sample size, the present study may not have captured a diversity of masculinities and thus a variety of gendered interpretations of suicidal behaviour may not be represented in the present study. It may therefore be valuable to perform a large-scale qualitative study with young men, such as conducting focus groups with young men who have previously engaged in suicidal behaviour or who have been found to be at risk by epidemiological research (for example men who are homosexual, transgender or bisexual or who have experienced substance abuse and mental health problems).

3. The portrayal of suicidal behaviour as a relational activity

Finally, the present study's participants understand suicidal behaviour in light of the human need to belong and the tension that arises when this belonging is thwarted. The findings indicate that supportive relationships are integral to understanding suicidal behaviour. This suggest that prevention and treatment approaches should therefore emphasise young men's relationships with family and peers, their emotional responsibility towards others and distorted cognitions such as the belief of not being loved and cared for by others. Moreover, emphasis should be placed on helping men to recognise and process emotions such as shame, anger and aloneness that arise in relationships with other people.

In order to develop such a treatment approach, an understanding of the individual's relationships with his/her social context becomes integral. Furthermore, conceptions of masculinity inevitably play a role in men's relationships with others and their understanding of their own emotions. It appears that the findings of the present study are interrelated and a therapeutic and preventative approach should be modelled accordingly.

In conclusion, the present study suggests that there are many ways to understand suicidal behaviour, all of which need to be considered when trying to make sense of the complexity of suicidal behaviour. The understanding that young men have about suicidal behaviour have not been extensively explored. Studying men's views on suicidal behaviour facilitates a dialogue, which not only helps researchers and mental health care professionals to gain a better understanding of suicidal behaviour, but also empowers the specific target group and individual patients to form an integral part of the prevention and treatment of their own and others suicidal behaviour. This study has merely attempted to initiate a dialogue in this regard and to indicate further avenues that future research may embark upon to deepen and extend the understanding of suicidal behaviour.

REFERENCES

Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*(1), 5-14. doi: 10.1037/0003-066X.58.1.5

Adinkrah, M. (2010). Better dead than dishonored: Masculinity and male suicidal behavior in contemporary Ghana. *Social Science & Medicine, 74*(4), 474-481. doi:10.1016/j.socscimed.2010.10.011

Agnew, R. (1998). The approval of suicide: A social-psychological model. *Suicide and Life-threatening Behavior, 28*(2), 205-225. doi: 10.1111/j.1943-278X.1998.tb00640.x

Ahrens, B., Linden, M., Zäske, H., & Berzewski, H. (2000). Suicidal behavior - Symptom or disorder? *Comprehensive Psychiatry, 41*(2), 116-121. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10746913

Ajzen, I. (1991). Theory of Planned Behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179-211. doi: 10.1016/0749-5978(91)90020-T

Ajzen, I. (2012). Martin Fishbein's legacy: The reasoned action approach. *The Annals of the American Academy of Political and Social Science, 640*(1), 11-27. doi:10.1177/0002716211423363

Anderson, M., Standen, P.J., & Noon, J.P. (2005). A social semiotic interpretation of suicidal behaviour in young people. *Journal of Health Psychology, 10*(3), 317-331. doi: 10.1177/1359105305051418

Arnautovska, U., & Grad, O. T. (2010). Attitudes toward suicide in the adolescent population. *Crisis, 31*(1), 22-29. doi:10.1027/0227-5910/a000009

Ayyash-Abdo, H. (2002). Adolescent suicide: An ecological approach. *Psychology in the Schools, 39*(4), 459-475. doi:10.1002/pits.10042

Bachman, J.G., Alcser, K.H., Doukas, D.J., Lichtenstein, R.L., Corning, A.D., & Brody, H. (1996). Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. *New England Journal of Medicine, 334*(5), 303–309. doi: 10.1056/NEJM199602013340506

Bagley, C., & Ramsay, R. (1989). Attitudes toward suicide, religious values and suicidal behaviour: Evidence from a community survey. In R. F. W. Diekstra, R. Maris, S. Platt, A. Schmidtke & G. Sonneck (Eds.), *Suicide and its prevention. The role of attitude and imitation* (pp. 78-90). Leiden: E. J. Brill.

Bagley, C., & Tremblay, P. (2000). Elevated rates of suicidal behaviour in gay, lesbian, and bisexual youth. *Crisis, 21*(3), 111-117. doi: 10.1027//0227-5910.21.3.111

Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review, 97*, 90-113. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/2408091

Baumeister, R.F., & Leary, M.R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*, 497–529. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7777651

Bearman, P. S. (1991). The social structure of suicide. *Sociological Forum, 6*(3), 501-524. doi:10.1007/BF01114474

Berman, A.L., & Jobes, D.A. (1991). *Adolescent suicide: Assessment and intervention.* Washington DC: American Psychological Association.

Boeije, H. (2010). *Analysis in qualitative research.* California: Sage Publications.

Boldt, M. (1982). Normative evaluations of suicide and death: A cross-generational study. *Omega, 13*(2), 145-157. doi: 10.2190/KANJ-0J0V-C49L-8Q7W

Boldt, M. (1988). The meaning of suicide: Implications of research. *Crisis, 9*(2), 93–108. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/3215039

Bowlby, J. (1973). *Attachment and Loss, Volume 2: Separation*. New York: Basic Books.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brownhill, S., Wilhelm, K., Barclay, L., & Schmied, V. (2005). 'Big build': Hidden depression in men. *Australian and New Zealand Journal of Psychiatry, 39*(10), 921–931. doi:10.1111/j.1440-1614.2005.01665.x

Brunero, S., Smith, J., Bates, E., & Fairbrother, G. (2008). Health professionals' attitudes towards suicide prevention initiatives. *Journal of Psychiatric and Mental Health Nursing, 15*(7), 588–594. doi:10.1111/j.1365-2850.2008.01278.x

Buie, D.H., & Maltsberger, J.T. (1983). *The practical formulation of suicide risk.* Cambridge, MA: Firefly Press.

Burrows, S., & Laflamme, L. (2008). Suicide among urban South African adolescents. *International Journal of Adolescent Medical Health, 20*(4), 519-528. Retrieved from http://www.degruyter.com/view/j/ijamh.2008.20.4/ijamh.2008.20.4.519/ijamh.2008.20.4.519.xml

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity.* London: Routledge.

Butler, J. (1993). *Bodies that Matter: On the Discursive Limits of "Sex".* London: Routledge.

Calder, L. (2004). *The state of suicidology in South Africa: A content analysis.* (Master's Thesis). Retrieved from http://hdl.handle.net/10413/2852

Canetto, S. S., & Cleary, A. (2011). Men, masculinities and suicidal behaviour. *Social Science & Medicine, 74*(4), 461-465. doi:10.1016/j.socscimed.2011.11.001

Canetto, S. S., & Lester, D. (1995). Gender and the primary prevention of suicide mortality. *Suicide and Life-Threatening Behavior, 25*(1), 58–69. doi: 10.1111/j.1943-278X.1995.tb00392.x

Canetto, S. S., & Lester, D. (1998). Gender, culture and suicidal behavior. *Transcultural Psychiatry, 35*(2), 163–191. doi: 10.1177/136346159803500201

Canetto, S.S. (1991). Gender roles, suicide attempts, and substance abuse. *The Journal of Psychology, 125*(6), 605-620. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1806663

Canetto, S.S. (1997). Meanings of gender and suicidal behaviour during adolescence. *Suicide and Life-threatening Behavior, 27*(4), 339-351. doi: 10.1111/j.1943-278X.1997.tb00513.x

Canetto, S.S., & Sakinofsky, I. (1998). Gender paradox in suicide. *Suicide and Life-threatening Behavior, 28*(1), 1-23. doi: 10.1111/j.1943-278X.1998.tb00622.x

Chandler, A. (2012). *Exploring the role of masculinities in suicidal behaviour.* (Samaritans Research Report: Men, suicide and society). Retrieved from http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20270912.pdf

Clarke, D.M. (1999). Autonomy, rationality and the wish to die. *Journal of Medical Ethics, 25*(6), 457-462. doi:10.1136/jme.25.6.457

Cleary, A. (2005). *Young men on the margins: Suicidal behaviour amongst young men.* Dublin: Katherine Howard Foundation.

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Sciences & Medicine, 74*(4), 498-505. doi: 10.1016/j.socscimed.2011.08.002

Cleary, A., & Brannick, T. (2007). Suicide and changing values and beliefs in Ireland. *Crisis, 28*(2), 82-88. doi:10.1027/0227-5910.28.2.82

Colucci, E. (2006). The cultural facet of suicidal behaviour: Its importance and neglect. *Australian e-Journal for the Advancement of Mental Health, 5*(3), 1-13. Retrieved from http://espace.library.uq.edu.au/view/UQ:82519

Connell, R.W. (1995). *Masculinities.* Berkeley, CA: University of California Press.

Connell, R.W. (2000). *The Men and the boys.* St Leonards, NSW: Allen & Unwin.

Connell, R.W., & Messerschmidt, J.W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender and Society, 19*(6), 829-859. doi: 10.1177/0891243205278639

Conner, K.R., & Ilgen, M.A. (2011). Substance use disorders and suicidal behaviour. In O'Connor, R. C., Platt, S. & Gordon, J. (Eds.), *International Handbook of suicide prevention: research, policy and practice* (pp. 181–198). Chichester, England: John Wiley.

Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine, 50*(10), 1385-1401. doi: 10.1016/S0277-9536(99)00390-1

Curtis, C. (2010). Youth perceptions of suicide and help- seeking : "They'd think I was weak or 'mental'." *Journal of Youth Studies, 13*(6), 37-41. doi:10.1080/13676261003801747

Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care, 41*(1), 14-21. doi:10.1111/j.0031-5990.2005.00004.x

Dahlen, E.R., & Canetto, S.S. (2002). The role of gender and suicide precipitant in attitudes toward nonfatal suicidal behavior. *Death Studies, 26*(2), 99–116. doi:10.1080/074811802753455235

De Leo, D. (2009). Cross-cultural research widens suicide prevention horizons. *Crisis, 30*(2), 59-62. doi:10.1027/0227-5910.30.2.59

De Leo, D., Burgis, S., Bertolote, J. M., Kerkhof, J. F. M., & Bille-Brahe, U. (2006). Definitions of suicidal behavior. *Crisis, 27*(1), 4-15. doi:10.1027/0227-5910.27.1.4

Denning, D.G., Conwell, Y., King, D., & Cox, C. (2000). Method choice, intent, and gender in completed suicide. *Suicide Life Threatening Behaviour, 30*(3), 282–288. doi: 10.1111/j.1943-278X.2000.tb00992.x

Domino, G. (2005). Cross-cultural attitudes towards suicide: The SOQ and a personal odyssey. *Archives of Suicide Research, 9*(2), 107-122. doi: 10.1080/138111110590903963

Domino, G., & Groth, M. (1997). Attitudes toward suicide: German and U.S. nationals. *Omega, 35*, 309–317. doi:10.2190/H1CB-YFJD-W51B-P741

Douglas, J. D. (1967). *The social meanings of suicide.* Princeton, New Jersey: Princeton University Press.

Dragun, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: Issues and findings. *Behavior Research and Therapy*, *41*(7), 755-776. doi:10.1016/S0005-7967(02)00190-0

Drum, D. J., Brownson, C., Denmark, A. B., & Smith, S. E. (2009). New data on the nature of suicidal crises in college students : Shifting the paradigm. *Practice*, *40*(3), 213-222. doi:10.1037/a0014465

Durkheim, E. (1951). *Suicide* (J.A.Spaulding, & G. Simpson, Trans.). New York: Free Press. (Original work published 1897).

Emslie, C., Ridge, D., Ziebald, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science & Medicine*, *62*(9), 2246-2257. doi:10.1016/ socscimed.2005.10.017

Erikson, E. (1968). *Identity: Youth, and crisis*. New York: W. W. Norton.

Eshun, S. (2003). Sociocultural determinants of suicide ideation: A comparison between American and Ghanaian college samples. *Suicide and Life-Threatening Behavior, 33*(1), 165–171. doi: 10.1521/suli.33.2.165.22779

Eskin, M. (1995). Adolescents' attitudes toward suicide, and a suicidal peer: A comparison between Swedish and Turkish high school students. *Scandinavian Journal of Psychology, 36*(2), 201–207. doi: 10.1111/j.1467-9450.1995.tb00979.x

Eskin, M., Voracek, M., Stieger, S., & Altinyazar, V. (2011). A cross-cultural investigation of suicidal behavior and attitudes in Austrian and Turkish medical students. *Social Psychiatry Psychiatric Epidemiology, 46*(9), 813–823. doi: 10.1007/s00127-010-0254-7

Evans, J., Frank, B., Oliffe, J.L., & Gregory, D. (2010). Health, Illness, Men and Masculinities (HIMM): A theoretical framework for understanding men and their health. *Journal of Men's Health, 8*(1), 7-15. doi:10.1016/j.jomh.2010.09.227

Fairbairn, G. (1995). *Contemplating suicide: The language and ethics of selfharm*. London: Routledge.

Flick, U. (2009). *An introduction to qualitative research.* Los Angeles: Sage.

Flisher, A.J., Joubert, G., & Yach, D. (1992). Mortality from external causes in South African adolescents. *South African Medical Journal, 81*, 77-80.

Freud, S. (1957). *Mourning and Melancholia.* In Standard Edition XIV. London: Hogarth Press. (Original work published 1917).

Gavin, H. (2008). *Understanding research methods and statistics in psychology.* London: SAGE Publications.

Gibb, B. E., Andover, M. S., & Beach, S. R. H. (2006). Suicidal ideation and attitudes towards suicide. *Suicide and Life Threatening Behaviors, 36*(1), 12-18. doi: 0.1521/suli.2006.36.1.12.

Gilchrist, H., & Sullivan, G. (2006). The role of gender and sexual relations for young people in identity construction and youth suicide. *Culture, Health & Sexuality, 8*(3), 195-209. doi:10.1080/13691050600699831

Goffman, E. (1959). *The presentation of self in everyday life.* New York: Doubleday.

Goffman, E. (1983). The interaction order. *American Sociological review, 48,* 1-17. Retrieved from http://www.jstor.org/stable/2095141

Greenhalgh, T., & Hurwitz, B. (1999). Narrative based medicine: Why study narrative. *British Medical Journal, 318,* 48-50. doi:10.1136/bmj.318.7175.48

Groves, S.A., & Sher, L. (2005). Gender differences in suicidal behavior and alcohol abuse in adolescents. *International Journal of Adolescent Medical Health, 17*(3), 307–309. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16231487

Hagerty, B.M.K., Lynch-Sauer, J., Patusky, K.L., Bouwsema, M., & Collier, P. (1992). Sense of belonging: A vital mental health concept. *Archives of Psychiatric Nursing, 1*(3), 172-177. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1622293 *

Harris, E.C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders. A meta-analysis. *British Journal of Psychiatry, 170*(3), 205-228. doi: 10.1192/bjp.170.3.205.

Hawton, K. (2000). Sex and suicide: Gender differences in suicidal behaviour. *The British Journal of Psychiatry, 117*(6), 484-485. doi: 10.1191/bjp.177.6.484

Henry, A.F. & Short, J.F. (1954). *Suicide and Homicide.* New York: Free Press.

Hirsch, J. K., & Barton, A. L. (2011). Positive social support, negative social exchanges, and suicidal behavior in college students. *Journal of American College Health, 9*(5), 393-398. doi:10.1080/07448481.2010.515635

Hjelmeland, H. & Knizek, B.L. (1999). Conceptual confusion about intentions and motives of nonfatal suicidal behaviour: A discussion of terms employed in the literature of

suicidology. *Archives of Suicide Research, 5*(4), 277-283. doi:10.1023/A:1009685700347

Hjelmeland, H. (2010). Cultural research in suicidology: Challenges and opportunities. *Suicidolgy Online, 1*(1), 34-52. Retrieved from http://www.suicidology-online.com/pdf/SOL-2010-1-34-52.pdf

Hjelmeland, H., & Knizek, B. L. (2004). The general public's views on suicide and suicide prevention, and their perception of participating in a study on attitudes towards suicide. *Archives of Suicide Research, 8*(4), 345-359. doi:10.1080/13811110490476725

Hjelmeland, H., & Knizek, B.L. (2010). Why we need qualitative research in suicidology. *Suicide & Life-threatening Behavior, 40*(1), 74-80. doi:10.1521/suli.2010.40.1.74

Hjelmeland, H., Akotia, C. S., Owens, V., Knizek, B. L., Nordvik, H., Schroeder, R., & Kinyanda, E. (2008). Self-reported suicidal behavior and attitudes toward suicide and suicide prevention among psychology students in Ghana, Uganda, and Norway. *Prevention, 29*(1) doi:10.1027/0227-5910.29.1.20

Hjelmeland, H., Knizek, B.L., Kinyanda, E., Musisi, S., Nordvik, H., & Svarva, K. (2008b). Suicidal behavior as communication in a cultural context: A comparative study between Uganda and Norway. *Crisis, 29*(3), 137-144. doi: 10.1027/0227-5910.29.3.137

Holtman, Z., Shelmerdine, S., & Flisher, A. (2011). Suicide in a poor rural community in the Western Cape, South Africa: Experiences of five suicide attempters and their families. *South African Journal of Psychology, 41*(3), 300-309. Retrieved from http://www.sabinet.co.za/abstracts/sapsyc/sapsy c_v41_n3_a5.html

Insel, B.J. & Gould, M.S. (2008). Impact of modelling on adolescent suicidal behaviour. *Psychiatric Clinics of North America, 31*(2), 293-316. doi:10.1016/j.psc.2008.01.007

Jaworski, K. (2003). Suicide and gender: Reading suicide through Butler's notion of performativity, *Journal of Australian Studies, 27*(76), 137-146. doi: 10.1080/14443050309387832

Jaworski, K. (2010 a). The author, agency and suicide. *Social Identities, 16*(5), 675-687. doi: 10.1080/13504630.2010.509572

Jaworski, K. (2010 b). The gender-ing of suicide. *Australian Feminist Studies, 25*(63), 47-61. doi: 10.1080/08164640903499752

Joe, S., Stein, D. J., Seedat, S., Herman, A., Williams, D. R., & Africans, S. (2012). Prevalence and correlates of non-fatal suicidal behaviour among South Africans. *The British Journal of Psychiatry, 192*, 310-311. doi:10.1192/bjp.bp.107.037697

Joiner, T. (2005). *Why people die by suicide.* Cambridge, MA, US: Harvard University Press.

Joiner, T.E., Hollar, D., & Van Orden, K.. (2006). On Buckeyes, Gators, Super Bowl Sunday, and the Miracle on Ice: "Pulling together" is associated with lower suicide rates. *Journal of Social & Clinical Psychology. 25*(2), 179–195. doi: 10.1521/jscp.2006.25.2.179

Jukkala, T. & Mäkinen, I.H. (2011). Acceptance of suicide in Moscow. *Social Psychiatry and Psychiatric Epidemiology, 46*(8), 753-765. doi: 10.1007/s00127-006-0074-y

Khasakhala, L., Sorsdahl, K., Harder, V., Williams, D., Stein, D., & Ndetei, D. (2011). Lifetime mental disorders and suicidal behaviour in South Africa. *African Journal of Psychiatry, 14*(2), 134-139. doi:10.4314/ajpsy.v14i2.5

Kimmel, M.S., 1986. Introduction toward men's studies. *American Behavioural Scientist, 29* (5), 517-529.

Kinyanda, E., Hjelmeland, H., & Musisi, S. (2005). Psychological factors in deliberate self-harm as seen in an urban African population in Uganda: A case-control study. *Suicide and Life-Threatening Behavior, 35*(4), 468-477.

Knizek, B.L. & Hjelmeland, H. (2007). A theoretical model for interpreting suicidal behaviour as communication. *Theory Psychology, 17*(5), 697-720. doi: 10.1177/0959354307081625

Knizek, B.L., Akotia, C.S., & Hjelmeland, H. (2010). A qualitative study of attitudes towards suicide and suicide prevention among psychology students in Ghana. *Omega, 62*(2), 169-186. Retrieved from http://logicalliving.blog.com/files/2011/04/Sucide-Two.pdf

Knizek, B.L., Kinyanda, E., Owens, V. & Hjelmeland, H. (2011). Ugandan men's perceptions of what causes and what prevents suicide. *Journal of Men, Masculinities and Spirituality, 5*(1), 4-21. Retrieved from http://www.jmmsweb.org/PDF/ volume5-number1/jmms-vol5-no1-pp004-021-knizek_et_al.pdf

Kodaka, M., Poštuvan, V., Inagaki, M., & Yamada, M. (2011). A systematic review of scales that measure attitudes towards suicide. *International Journal of Social Psychiatry, 57*(4), 338-361. doi:10.1177/0020764009357399

Konick, L. C., & Gutierrez, P. M. (2005). Testing a model of suicide ideation in college students. *Suicide & Life-threatening Behavior, 35*(2), 181-92. doi:10.1521/suli.35.2.181.62875

Kral, M.J. (1994). Suicide as social logic. *Suicide & Life-Threatening Behavior, 24*(3), 245-55.doi: 10.1111/j.1943-278X.1994.tb00749.x

Kral, M.J. (1998). Suicide and the internalization of culture: Three questions. *Transcultural Psychiatry, 35*(2), 221- 233. doi:10.1177/136346159803500203

Langhinrichsen-Rohling, J., Friend, J., & Powell, A. (2009). Adolescent suicide, gender, and culture: A rate and risk factor analysis. *Aggression and Violent Behavior, 14*(5), 402-414. doi: 10.1016./j.avb.2009.06.010

Langhinrichsen-Rohling, J., Sanders, A., Crane, M., & Monson, C.M. (1998). Gender and history of suicidality: Are these factors related to U.S. college students' current suicidal thoughts, feelings, and actions? *Suicide and Life-threatening Behavior, 28*(1), 127-142. doi: 10.1111/j.1943-278X.1998.tb00631.x

Laubscher, L. R. (2003). Suicide in a South African town : A cultural psychological investigation. *South African Journal of Psychology, 33*(3), 133-143. Retrieved from http://www.sabinet.co.za/abstracts/sapsyc/sapsyc_v33_n3_a1.html

Leenaars, A. A. (2002a). In defense of the idiographic approach: Studies of suicide notes and personal documents. *Archives of Suicide Research, 6*, 19-30. doi:10.1080/13811110213125

Leenaars, A.A. (2002b). The quantitative and qualitative in suicidological science: An Editorial. *Archives of Suicide Research, 6* (1), 1-3. doi:10.1080/13811110290100183

Lester, D. (1989). *Suicide from a sociological perspective.* Springfield, Illinois: C.C. Thomas.

Lester, D. (1995). Preventing suicide in women and men. *Crisis, 16*(2), 79-84. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7587295

Lester, D., & Icli, T. (1990). Beliefs about suicide in American and Turkish students. *Journal of Social Psychology, 130*(6), 825–827. doi:10.1080/00224545.1990.9924635

Lévi-Strauss, C. (1980). *Mythos und Bedeutung.* Frankfurt am Main: Suhrkamp.

Li, X., & Phillips, M. R. (2010). The acceptability of suicide among rural residents, urban residents, and college students from three locations in China. *Crisis, 31*(4), 183-193. doi:10.1027/0227-5910/a000024

Linehan, M.M. (1973). Suicide and attempted suicide: Study of perceived sex differences. *Perceptual and Motor Skills, 37*(1), 31–34. doi: 10.2466/pms.1973.37.1.31

Loots, S. (2008). *The role of exposure to suicide and coping strategies in the suicidal ideation of adolescents.* (Master's thesis). Retrieved from http://etd.uovs.ac.za/ETD-db/theses/available/etd-04082009-142539/unrestricted/LootsS.pdf

Luoma, J. B., Martin, C. E., & Pearson J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *The American Journal of Psychiatry, 159*(6), 909-916. doi:10.1176/appi.ajp.159.6.909

Luoma, J.B., & Pearson, J.L. (2002). Suicide and marital status in the United States, 1991–1996: Is widowhood a risk factor? *American Journal of Public Health, 92*(9), 1518–1522. doi: 10.2105/AJPH.92.9.1518.

MacLean, P. D. (1990). *The Triune Brain in Evolution.* New York: Plenum Press.

Madu, S.N., & Matla, M.P. (2003). The prevalence of suicidal behaviours among secondary school adolescents in the Limpopo Province, South Africa. *South African Journal of Psychology, 33*(2), 126-132. Retrieved from http://www.sabinet.co.za/abstracts/sapsyc/sapsyc_v33_n2_a8.html

Mäkinen, I.H., & Wasserman, D. (2001). Some social dimensions of suicide. In D. Wasserman (Ed), *Suicide: An unnecessary death* (pp. 101-108). London: Martin Dunitz.

Mann, J.J. (2002). A current perspective of suicide and attempted suicide. *Annals of Internal Medicine, 136*(4), 302-311. Retrieved from https://secure.muhealth.org/~ed/students/articles/aim_136_p302.pdf

Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A…. Hendin, H. (2005). Suicide prevention strategies: A systematic review. *The Journal of the American Medical Association, 294* (16), 2064–274. Retrieved from http://www.nosp.ie/html/research.html

Maris, R.W. (1997). Social and familial risk factors in suicidal behaviour. *Psychiatric Clinics of North America. 20*(3), 520-550. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9323311

Marsh, I. (2011). *Suicide: Foucault, history and truth.* New York: Cambridge University Press.

Martin, P.Y. (2003). "Said and done" versus "saying and doing": Gendering practices, practicing gender at work. *Gender & Society. 17*(3), 342–366. doi: 10.1177/0891243203017003002

Masango, S., Rataemane, S., & Motojesi, A. (2008). Suicide and suicide risk factors : A literature review. *Family Practice, 50*(6), 25-29. Retrieved from http://www.ajol.info/index.php/safp/article/view/13477

Maslow, A. (1954). *Motivation and personality.* New York, NY: Harper.

Mayekiso, T. (2010). Attitude of black adolescents toward suicide. *Southern African Journal of Child and Adolescent Mental Health, 7*(1), 37-41. doi:10.1080/16826108.1995.96324 55

McAuliffe, C., Corcoran, P., Keely, H.S., &Perry, I.J. (2003). Risk of suicide ideation associated with problem-solving ability and attitudes towards suicidal behaviour in university students. *Crisis, 24*(4), 160-167. doi:10.1027//0227-5910.24.4.160.

McDermont, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality, 10*(8), 815-829. doi:10.1080/13691050802380974

McIntosh, J.L. (2002). Quantitative methods in suicide research: Issues associated with official statistics. *Archives of Suicide Research, 6*(1), 41-54. doi: 10.1080/1381111 10213123

Meel, B.L. (2003). A study on the incidence of suicide by hanging in the subregion of Transkei, South Africa. *Journal of Clinical Forensic Medicine, 10,* 153-157. doi:10.1016/S1353-1131(03)00077-4

Menninger. (1938). *Man against himself.* New York: Harcourt, Brace.

Michel, K., & Valach, L. (2001). Suicide as goal-directed action. In K. Van Heeringen (Ed.), *Understanding Suicidal Behaviour* (pp. 231–254). Chichester, England: John Wiley & Sons.

Michel, K., Valach, L., & Waeber, V. (1994). Understanding deliberate self-harm: The patients' views. *Crisis, 15*(4), 172-178. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7729149

Miller, J. S., Segal, D. L., & Coolidge, F. L. (2001). A comparison of suicidal thinking and reasons for living among younger and older adults. *Death Studies, 25*(4), 357-65. doi:10.1080/07481180126250

Mokros, H.B. (1995). Suicide and Shame. *The American Behavioural Scientist. 38*(8), 1091-1103. doi: 10.1177/0002764295038008005

Möller-Leimkühler, A.M. (2003). The gender gap in suicide and premature death or: why are men so vulnerable? *European Archives of Psychiatry and Clinical Neuroscience, 253*(1), 1-8. doi:10.1007/s00406-003-0397-6

Moosa, M.Y.H., Jeenah, F.Y., & Vorster, M. (2005). Repeat non-fatal suicidal behaviour in a Johnannesburg hospital. *South African Journal of Psychiatry, 11*(3), 84-88. Retrieved from http://www.sajp.org.za/index.php/sajp/article/view/109/97

Mueller, M., & Waas, G. (2002). College students' perceptions of suicide: The role of empathy on attitudes, evaluation, and responsiveness. *Death studies, 26*(4), 325-41. doi:10.1080/074811802753594709

National Injury Mortality Surveillance System. (2008). *A profile of fatal injuries in South Africa-10th Annual Report of the National Injury Mortality Surveillance System.* Retrieved from http://www.mrc.ac.za/crime/nimss2008.pdf

Ndosi, N. K., Mbonde, M. P., & Lyamuya, E. (2004). Profile of suicide in Dar es Salaam. *The East African Medical Journal, 78*, 493-496. Retreived from http://www.ajol.info/index. php/eamj/article/view/9157/2079

Neeleman, J., & Lewis, G. (1999). Suicide, religion, and socioeconomic conditions. An ecological study in 26 countries. *Journal of Epidemiology and Community Health, 53*, 204–210.

Niehaus, I. (2012). Gendered endings: Narratives of male and female suicides in the South African Lowveld. *Culture, Medicine and Psychiatry, 36*(2), 327-347. doi: 10.1007/s11013-012-9258-y

O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine, 61*(3), 503-516. doi: 10.1016/j.socscimed.2004.12.008

O'Carroll, P. W., Berman, L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the tower of babel: A nomenclature for suicidology. *Suicide & Life-threatening Behavior, 26*(3), 237-52. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8897663

O'Connor, R. & Sheehy, N. (2001). *Understanding suicidal behaviour.* Leicester: British Psychological Society Books.

O'Connor, R.C. (2003). Suicidal behaviour as a cry of pain: Test of a psychological model. *Archives of Suicide Research, 7*, 279-308. doi: 10.1080/138111110390226417

O'Connor, R.C. (2011). Towards an Integrated Motivational-Volitional Model of Suicidal Behaviour. In R. C. O'Connor, S. Platt & J. Gordon (Eds.), *International handbook of suicide prevention: Research, policy and practice* (pp. 181-198). Chichester, England: John Wiley.

Oliffe, J. & Mroz, L. (2005). Men interviewing men about health and illness: Ten lessons learned. *Journal of Men's Health and Gender, 2*(2), 257–260. doi:10.1016%2fj.jmhg. 2005.03.007

Oliffe, J. L., Kelly, M. T., Bottorff, J. L., Johnson, J. L., & Wong, S. T. (2011). "He's more typically female because he's not afraid to cry": Connecting heterosexual gender

relations and men's depression. *Social Science & Medicine, 73*(5), 775-782. doi:10.1016/j.socscimed.2011.06.034

Oliffe, J.L., Ogrodniczuk, J.S., Bottorff, J.L., Johnson, J.L., & Hoyak, K. (2012). "You feel like you can't live anymore": Suicide from the perspectives of men who experience depression. *Social Science & Medicine, 74*(4), 505-514. doi:10.1016/j.socscimed.2010.03.057

Oliver, L. (2011). *Delirium.* New York: Harper Collins.

Osafo, J., Hjelmeland, H., Akotia, C. S., & Knizek, B. L. (2011a). The meanings of suicidal behaviour to psychology students in Ghana: A qualitative approach. *Transcultural psychiatry, 48*(5), 643-59. doi:10.1177/1363461511417319

Osafo, J., Hjelmeland, H., Akotia, C.S., & Knizek, B.L. (2011b). Social injury: An interpretative phenomenological analysis of the attitudes towards suicide of lay persons in Ghana. *International Journal of Qualitative Studies on Health and Well-being, 6*(4), 8708-8718. doi:10.3402/qhw.v6i4.8708.

Osafo, J., Knizek, B. L., Akotia, C. S., & Hjelmeland, H. (2011a). Influence of religious factors on attitudes towards Suicidal Behaviour in Ghana. *Journal of Religion and Health.* Advance online publication. doi:10.1007/s10943-011-9487-3

Osafo, J., Knizek, B.L., Akotia, C.S., & Hjelmeland, H. (2011b). Attitudes of psychologists and nurses toward suicide and suicide prevention in Ghana: A qualitative study. *Journal of Nursing Studies.* Advance online publication. Retrieved from http://www.ncbi.nlm.nih.gov/ pubmed/22177569

Payne, S., Swami, V., & Stanistreet, D.L. (2008). The social construction of gender and its influence on suicide: A review of the literature. *Journal of Men's Health, 5*(1), 23-35. doi:10.1016/j.jomh.2007.11.002

Peltzer, K., Cherian, V. I., & Cherian, L. (1998). Attitudes toward suicide among South African secondary school pupils. *Psychological Reports, 83*, 1259-1265. Retrieved from http://www.amsciepub.com/doi/abs/10.2466/pr0.1998.83.3f.1259

Peltzer, K., Cherian, V. I., & Cherian, L. (2000). Cross-cultural attitudes towards suicide among South African secondary school pupils. *East African Medical Journal, 77*(3), 165-167. Retrieved from http://www.ajol.info/index.php/eamj/article/view/46615

Phillips, D.P. (1974). The influence of suggestion on suicide: Substantive and theoretical implications of the Werther Effect. *American Sociological Review, 39*, 340-354. Retrieved from http://www.jstor.org/stable/2094294

Pillay, A.L., & Wassenaar, D.R. (1997). Recent stressors and family satisfaction in suicidal adolescents in South Africa. *Journal of Adolescence, 20*, 155-162. doi: 10.1006/jado. 1996.0073

Pollock, L.R., & Williams, J.M.G. (1998). Problem solving and suicidal behaviour. *Suicide and life-threating behaviour, 28*(4), 375-387. doi:10.1111/j.1943-278X.1998.tb00973.x

Porter, K., Johnson, P.H., & Petrillo, J. (2009). Priority health behaviours among African students. *International Electronic Journal of Health Education, 12*(1), 222-243. Retrieved from http://www.aahperd.org/aahe/publications/iejhe/loader.cfm?csModule =security/get file&pageid=39726

Portes, P.R., Sandhu, D.S., & Longwell-Grice, R. (2002). Understanding adolescent suicide: A psychosocial interpretation of developmental and contextual factors. *Adolescence, 37*, 1-5. Retrieved from http://www.nvcc.edu/home/rgreen/PowerWeb05/Understanding%20Adolescent%20Suicide.pdf

Pretorius, J.D. (1967). *A psychodynamic study of a group of persons with one or more suicidal attempts.* (Unpublished master's thesis). University of Pretoria: Pretoria, South Africa.

Ramsey, R., & Bagley, C. (1985). The prevalence of suicidal behaviors, attitudes and associated social experiences in an urban population. *Suicide and Life-Threatening Behavior, 15*(3), 151–167. doi:10.1111/j.1943-278X.1985.tb00941.x

Remafedi, G., French, S., Story, M., Resnick, M.D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health, 88*(1), 57-60. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1508407/

Ribeiro, J.D., & Joiner, T.E. (2009).The interpersonal-psychological theory of suicidal behavior: Current status and future directions. *Journal of Clinical Psychology, 65*(12), 1291-1299. doi:10.1002/jclp.20621

Ringel, E. (1974). *Selbstmord – ein Appell an die Anderen.* München: Kaiser.

Rochat, P. (2009). *Others in Mind: Social Origins of Self-Consciousness.* New York: Cambridge University Press.

Roen, K., Scourfield, J., & McDermont, E. (2008). Making sense of suicide: A discourse analysis of young people's talk about suicidal subjecthood. *Social Science & Medicine, 67*(12), 2089-2097. doi: 10.1016/j.socscimed.2008.09.019

Russel, S.T., & Toomey, R.B. (2012). Men's sexual orientation and suicide: Evidence for U.S. adolescent-specific risk. *Social Science and Medicine, 74*(4), 523–529.doi: 10.1016/j.socscimed.2010.07.038

Salander Renberg, E., & Jacobsson, L. (2003). Development of a questionnaire on attitudes towards suicide (ATTS) and its application in a Swedish population. *Suicide & Life-threatening Behavior, 33*(1), 52-64. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12710540

Salander Renberg, E., Hjelmeland, H., & Koposov, R. (2008). Building models for the relationship between attitudes toward suicide and suicidal behavior: Based on data from general population surveys in Sweden, Norway, and Russia. *Suicide & Life-threatening Behavior, 38*(6), 661-75. doi:10.1521/suli.2008.38.6.661

Schlebusch, L. (1995). *Suicidal Behaviour 3. Proceedings of the third Southern African Conference on Suicidology.* Durban; Sub-department of Medically Applied psychology, University of Natal.

Schlebusch, L. (2005). *Suicidal behaviour in South Africa.* Scottsville: University of KwaZulu-Natal University Press.

Schlebusch, L., Vawda, N.B.M, & Bosch, B.A. (2003). Suicidal behaviour in black South Africans. *Crisis, 24*(1), 24-28. doi: 10.1027//0227-5910.24.1.24

Schotte, D., & Clum, G. (1987). Problem-solving skills in suicidal psychiatric patients. *Journal of Consulting and Clinical Psychology, 55*, 49-54. Retrieved from http://psycnet.apa.org/doi/10.1037/0022-006X.55.1.49

Schrock, D., & Schwalbe, M. (2009). Men, masculinity and manhood acts. *Annual Review of Sociology 35*(1), 277-95. doi:10.1146/annurev-soc-070308-115933

Scourfield, J., Jacob, N., Smalley, N., Prior, L., & Greenland, K. (2007). Young people's gendered interpretations of suicide and attempted suicide. *Child and Family Social Work, 12*(3), 248- 257. doi: 10.1111/j.1365-2206.2007.00498.x

Segal, D. L., Mincic, M. S., Coolidge, F. L., & O'Riley, A. (2004). Attitudes toward suicide and suicidal risk among younger and older persons. *Death studies, 28*(7), 671-678. doi:10.1080/07481180490476524

Shilubane, H.N., Ruiter, R.A.C., Bos, A.E.R., van der Borne, B., James, S., & Reddy, P.S. (2012). Psychosocial determination of suicide attempts among Black South African adolescents: a qualitative analysis. *Journal of Youth Studies, 15*(2), 177-189. doi: 10.1080/13676261.2011.634400

Shneidman, E. (1987). A psychological approach to suicide. In G.R. Van den Bos & B.K. Bryant (eds.), *Cataclysms, crises, and catastrophes: Psychology in action* (pp.147-183). Washington: American Psychological Association.

Shneidman, E. S. (1993). *Suicide as psychache: A clinical approach to self-destructive behavior*. London: Jason Aronson.

Shneidman, E. S. (1996). *The suicidal mind.* New York: Oxford University Press.

Shneidman, E.S. (1981). *Suicide thoughts and reflections, 1960-1980: A special issue of Suicide and life-threatening behaviour.* London: Human Sciences Press.

Silenzio, V. M. B., Peña, J. B., Duberstein, P. R., Cerel, J., & Knox, K. L. (2007). Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *American Journal of Public Health, 97*(11), 2017–2019. doi: 10.2105/AJPH.2006.095943

Silverman, D. 2010. *Interpreting qualitative data.* London: SAGE Publications.

Silverman, M.M. (2006). The language of suicidology. *Suicide and Life-threatening Behavior, 36*(5), 519-532. doi: 10.1521/suli.2006.36.5.519

Simmons, C. (2008). *A profile of the fatal injury mortalities and suicides among children and youth in the Stellenbosch district.* (Master's Thesis). Retrieved from http://scholar.sun.ac. za/handle/10019.1/1864

Skogman, K. & Öjehagen, A. (2003). Motives for suicide attempts – the views of patients. *Archives of suicide research, 7*(3), 193-206. doi: 10.1080/138111110390214654

Skogman, K. (2006). *Understanding suicidality: Suicide risk, sex differences and views of suicide attempters.* (Master's Thesis). Retrieved from http://lup.lub.lu.se/luur/ download?func=downloadFile&fileOId=546095

Smalley, N., Scourfield, J., & Greenland, K. (2005). Young people, gender and suicide: A review of research on the social context. *Journal of Social Work, 5*(2), 133-154. doi: 10.1177/1468017305054953

Stice, B. D., & Canetto, S. S. (2008). Older adult suicide : Perceptions of precipitants and protective factors. *Clinical Gerontologist, 31*(4), 4-30. doi:10.1080/073171108019 47144

Swami, V., Stanistreet, D., & Payne, S. (2008). Masculinities and Suicide. *The Psychologist, 21*(4), 308-311. Retrieved from http://www.thepsychologist.org.uk/archive/archive_ home.cfm/volumeID_21-editionID_159-ArticleID_1332getfile_getPDF/the psychologist/0408swam.pdf

Taylor, S. (1982). *Durkheim and the study of suicide.* London: Macmillan.

Thorlindsson, T., & Bjarnason, T. (1998). Modeling Durkheim on the micro level: A study of youth suicidality. *American Sociological Review, 63*(1), 94-110.

Tomlinson, M. (2007). The case of Northern Ireland: Suicide and young people. *Child Care in Practice, 13*(4), 435-443.doi:10.1080/13575270701504802

Van Hooff, A.J.L. (2000). A historical perspective on suicide. In R.W. Maris, A.L. Berman, M.M. Silverman, B.M. Bongar (Eds.), *Comprehensive Textbook of Suicidology* (pp.96-123). New York: Guilford Press.

Van Orden, K.A., Witte, T.K., Cukrowicz, K.C., Braithwaite, S., Selby, E.A., & Joiner, T.E. (2010). The Interpersonal Theory of Suicidal Behavior. *Psychological Reviews*, *117*(2), 575- 600. doi: 10.1037/a0018697.

Vijayakumar, L., Pirkis, J., & Whiteford, H. (2005). Suicide in developing countries (3): Prevention efforts. *Crisis, 26*(3), 120-124. doi: 10.1027/0227-5910.26.3.120

Wenzel, A., & Beck, A. T. (2008). A cognitive model of suicidal behavior: Theory and treatment. *Applied and Preventive Psychology*, *12*(1), 189–201. doi: 10.1016/j.appsy.2008.05.001

West, C., & Zimmerman, D. (1987). Doing gender. *Gender & Society, 1*(2), 125–151. doi: 10.1177/0891243287001002002

Whetherell, M. & Edley, N. (1999). Negotiating hegemonic masculinity: Imaginary positions and psycho-discursive practices. *Feminism and Psychology*, *9*(3), 335-356. doi: 10.1177/0959353599009003012

Whitehead, S. M. (2002). *Men and masculinities.* Cambridge: Polity Press.

Williams, J. M. G. (1997). *The Cry of Pain.* London:Penguin.

Williams, J. M. G. (2001). *Suicide and attempted suicide. Understanding the cry of pain.* London: Penguin.

Williams, J. M. G., & Pollock, L. R. (2000). The psychology of suicidal behaviour. In K. Hawton & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 79-93). Chichester: John Wiley & Sons.

Williams, J. M. G., & Pollock, L. R. (2001). Psychological aspects of the suicidal process. In K. van Heeringen (Ed.), *Understanding suicidal behaviour* (pp. 76-93). Chichester: John Wiley & Sons.

Winnicott, D.W. (1987). *The child, the family and the outside world.* Reading, MA: Addision-Wesley.

Witte, T.K., Smith, A.R., & Joiner, T.E. (2010). Reason for cautious optimism? Two studies suggesting reduced stigma against suicide. *Journal of Clinical Psychology, 66*(6), 611-626. doi: 10.1002/jclp.20691

World Health Organization. (2002). *World Report on Violence and Health*. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/index.html

World Health Organization. (2007). *Country reports and charts available.* Retrieved from. http://www.who.int/mental_health/media/southafr.pdf

Zemaitiene, N., & Zaborskis, A. (2005). Suicidal tendencies and attitude towards freedom to choose suicide among Lithuanian schoolchildren: Results from three cross-sectional studies in 1994, 1998, and 2002. *BMC Public Health, 5,* 1-9. Retrieved from http://www.biomedcentral.com/1471-2458/5/83

APPENDICES

Appendix A: Suicide rates in South Africa

Age (years)	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	All
Males	6	92	86	64	37	18	7	3	316
Females	2	38	18	16	12	9	2	7	104
Total	8	130	104	80	49	27	9	10	420

Figure A1. Number of suicides by age group and gender, South Africa, 2007. Reprinted from"Country reports and charts available." by World Health Organisation, 2007, Retrieved from. http://www.who.int/mental_health/media/southafr.pdf.

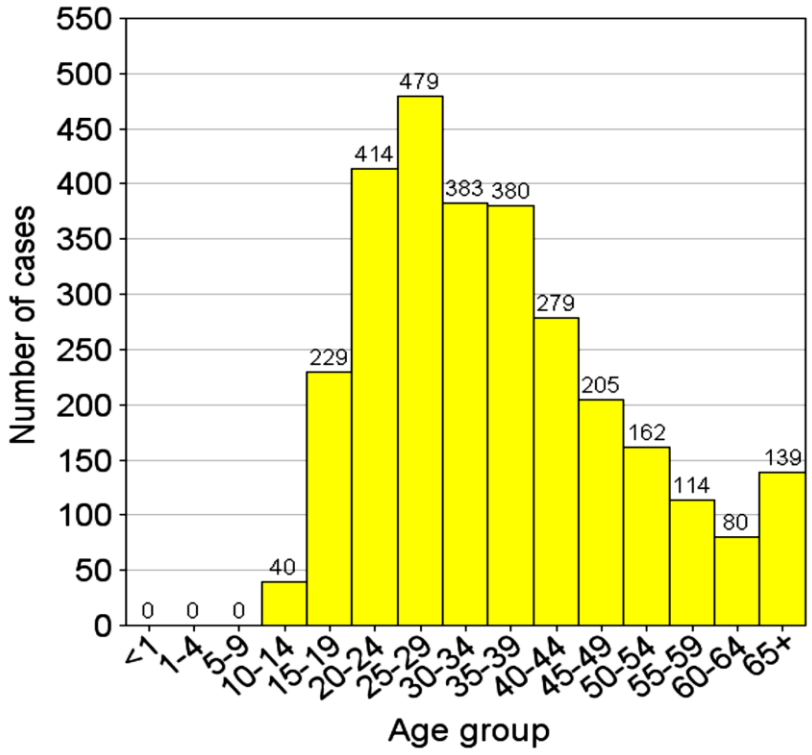

Figure A2. Suicide by age in South Africa, 2008. Reprinted from "A profile of fatal injuries in South Africa-10th Annual Report of the National Injury Mortality Surveillance System." by National Injury Mortality Surveillance System, 2008, Retrieved from http://www.mrc.ac.za/crime/nimss2008.pdf

Appendix B: Stellenbosch University Human Research Ethics Committee: Letter of Ethical Clearance

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Approval Notice
New Application

24-May-2012
MEISSNER, Birte Linda

Ethics Reference #: S12/05/118

Title: **A qualitative investigation of the attitutes , beliefs and myths of young male South in African towards suicidal behavior, helps seeking and the role of the social media mediating these behaviours.**

Dear Miss Birte MEISSNER,

The **New Application** received on **04-May-2012**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **20-May-2012** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **20-May-2012 -20-May-2013**

Please remember to use your **protocol number** (**S12/05/118**) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number projects may be selected randomly for an external audit.
Translation of the consent document in the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard REC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further help, please contact the REC office at 0219389657.

Included Documents:
Synopsis
Checklist
Protocol
Investigators declaration
Consent Form

Sincerely,

Franklin Weber
REC Coordinator
Health Research Ethics Committee 1

Appendix C: Stellenbosch University Institutional Clearance

UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
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13 June 2012

Ms B. Meissner
Department of Psychology
Stellenbosch University

Dear Ms Meissner,

Concerning research project: ***A qualitative investigation of the attitudes, beliefs and myths of young male South Africans towards suicidal behaviour, help seeking and the role of the social media in mediating these behaviours***

Hereby institutional permission is granted to gather information from Stellenbosch University students, by means of semi-structured interviews, for the purpose of this research project. This permission is subject to the requirements that students participate on a voluntary basis, that no personal details of such participants be captured and published, and therefore that participants remain anonymous at all times.

Jan Botha
Senior Director: Institutional Research and Planning

Afdeling Institusionele Navorsing en Beplanning • Institutional Research and Planning Division
Privaatsak/Private Bag X1 • Stellenbosch • 7602 • Suid-Afrika/South Africa
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Appendix D: Participant information sheet and informed consent form

PARTICIPANT INFORMATION AND INFORMED CONSENT FORM FOR RESEARCH

TITLE OF RESEARCH PROJECT: A qualitative investigation of the attitudes, beliefs and myths of young male South Africans towards suicidal behaviour and help-seeking for suicidal behaviour

REFERENCE NUMBER:

RESEARCHERS: Ms BL Meissner, Dr JR Bantjes, Prof SA Kagee

ADDRESS: Department of Psychology, Stellenbosch University, Stellenbosch, 7600

CONTACT NUMBER: 078 848 4258

We would like to invite you to participate in a research study and share with us your views about suicidal behaviour and help-seeking for suicidal behaviour.

The study is conducted by Ms Birte Linda Meissner (Masters Psychology student (by thesis) at Stellenbosch University), Dr Jason Bantjes (Lecturer and researcher at Stellenbosch University) and Prof Ashraf Kagee (Lecturer and researcher at Stellenbosch University).

Please take some time to read the information presented here which will explain the details of this project. Please ask the study staff (Ms BL Meissner or Dr J Bantjes) any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved.

Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

This research study has been approved by the ethics **Committee for Human Research at Stellenbosch University** and it will be conducted according to international and locally accepted ethical guidelines for research, namely the Declaration of Helsinki, Guidelines on Ethics for Medical and Genetic Research of the Medical Research Council of South Africa (MRC).

What does this particular research study involve?

The study will be conducted at the Department of Psychology in Stellenbosch. We aim to recruit 10 participants for qualitative interviews.

In South Africa nearly two-thirds of suicide victims are between 15 and 29 years of age and four times more males than females complete suicide. Despite extensive quantitative research on an international level, research on suicide in South Africa is still lacking with regards to accurate statistics and qualitative research, both of which is needed to develop a more comprehensive national prevention program in South Africa. Most findings in the field of suicidology derive from data from mortality records or hospital patients. There is still a lack of qualitative knowledge about the prevalent attitudes, beliefs and myths about suicidal behaviour and help-seeking for suicidal behaviour among young populations and males in non-clinical settings. The present study seeks to address this gap in the literature by investigating South African male students' views on suicidal behaviour and help-seeking for suicidal behaviour.

Why have you been invited to participate?

20 to 30 males between the ages of 18-25 years are invited to participate in the study on a voluntary basis and confidentially share their views on young South African male suicidal and help-seeking behaviour.

What procedures will be involved in this research?

After written informed consent has been received, a semi-structured, face-to-face interview will be conducted. The interview will last between forty-five minutes to an hour and is held in the privacy of an office at the Wilcocks building on Stellenbosch University Main Campus or the Welgevallen house in Suidwal Street, which houses the Clinical Psychology division of the Stellenbosch University Department of Psychology, at a convenient time negotiated by the researcher and the participant. Time is allocated afterwards for debriefing purposes, where the participants will get time to reflect on the interview and referral is suggested in case psychological distress is experienced afterwards. Interviews are tape-recorded so that they can to be transcribed verbatim for analysis. All information will be kept confidentiality and the identity of all the participants will remain anonymous.

Are there any risks involved in this study?

Due to the sensitive nature of the topic of suicidal behavior as well as social stigma associated with suicide, the interview may evoke emotional reactions. Please be prepared for emotional responses that may arise.

Are there any benefits to your taking part in this study and will you get told your results?

Publication of the results in the form of a thesis and a scientific paper will shed light upon the meanings young males assign to suicidal behavior and help-seeking, and may help to inform how to possibly prevent suicidal behavior amongst young male students in South Africa in the future.

What will happen in the event of some form distress occurring as a direct result of your taking part in this research study?

If you experience psychological distress as a direct result of participating in the interview, you can seek help at the Centre for Student Counselling and Development in Victoria Street on Stellenbosch Main Campus (for more information see http://www.sun.ac.za/counselling) or contact the 24-Hour Psychology Crisis Service (082 557 0880).

Will you be paid to take part in this study and are there any costs involved?

After the interview, you will be reimbursed for your participation time with a R40 meal voucher redeemable at the Neelsie Student Centre on the Stellenbosch University Main Campus. There will be no costs involved for you, if you do take part.

How will your confidentiality be protected?

The information collected will be treated as confidential and protected. If it is used in a publication or thesis, the identity of individual participants will remain anonymous. Only the researcher (Birte Meissner) and her supervisors (Dr Jason Bantjes, Prof Ashraf Kagee) will have access to the information.

Declaration by participant

By signing below, I …….…… agree to take part in a research study entitled **A qualitative investigation of the attitudes of young male South Africans towards suicidal behaviour and help seeking for suicidal behaviour.** I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.

Signed at (*place*) ..... on (*date*) .....

....

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* …… declare that:

- I explained the information in this document to ……..……...
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research as discussed above.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2009.

....

Signature of investigator **Signature of witness**

Appendix E: Interview Schedule

Part 1: Personal views

1. Can you tell me about what prompted you to volunteer for this study?
2. Can you tell me about your experience of suicide and suicidal individuals? (Do you know anyone who has killed themselves or tried to? Have you ever thought about it? Tried it? Why? What stopped you?)
3. What do you think are the reasons why people complete suicide? And attempt suicide?
4. It seems that men in SA are four times more likely to complete suicide than women. Can you tell me why you think this might be the case?
5. It seems like young men (16 – 30 y) are particularly at risk of killing themselves. Can you tell me why this might be true in SA?
6. What do you think could be done to reduce the incidence of suicide among young SA men? What strategies could work?
7. Some people think it is morally inacceptable to complete suicide while others think people have a right to take their own life. What is your opinion about this? Is suicide justifiable? If so under what circumstances?

Part 2: Vignettes

Academic pressure. Josh was a 19 year-old male who was three months into his first year of studies at university. The previous year he passed his matric with distinctions in some subjects. However, at university he was barely passing, despite spending most of his free time studying and declining socials with friends. One night after an exam, he hanged himself.

Job security in South Africa. Chris was a 25 year-old male who was nearing the end of his final year of studies at university. He applied for a job to a number of companies

countrywide, but his applications were all turned down. He and a friend then had plans to open their own business and applied for a loan. The day the loan was declined, Chris shot himself to death.

Relationship problems. Marc was a 20 year-old male who was six months into his second year of studies at university. While surfing Facebook one day, he learned that his girlfriend was involved in another relationship. After that, he began to abuse a lot of alcohol. One evening, he refused to go to the gym with his buddies, which was unusual. That night, Marc shot himself to death.

Mental illness. Daniel was a male student, who had recently turned 21. Daniel was known as an outgoing person with a great sense of humour. In the last months he had however withdrawn himself from his friends, spending most of his time sleeping or playing video games. He barely attended classes and drank a lot of alcohol. His flatmate took him to see a psychologist at the university counselling centre, who diagnosed him with depression. He seemed to be doing better with the help of therapy. Yet, one evening he slit open his wrists and bled to death.

1. What is your take on what (Josh/Chris/Marc/Daniel) did? Was this understandable / justifiable / preventable?
2. How do you think could the suicide be avoided?
3. Given that you know (Josh/Chris/Marc/Daniel) and are aware of his distress, how would you respond

Part 3: Help-seeking for psychological distress

1. Personal:

a. Can you think of a time that was emotionally difficult for you? Can you tell me about it?
b. How did you deal with the situation? Where did you get support? Who do you turn to when things are difficult or you need support?
c. Do you think this is how men typically deal with difficult situations/emotions?

2. Peer:

a. Can you think of a time when a mate/friend was not ok? Can you tell me about it?
b. How did you know he was not ok/not coping?
c. How did you respond to him?
d. Do you think this is how men typically respond to a friend that is not ok/not coping?

3. General:

a. What is your observation of how young men in SA access support?
b. Where do they find support/ how do they deal with difficult emotions?
c. How do they communicate distress/ not-coping?

Debriefing

1. What was it like for you to take part in this research? / What was it like to answer the questions?
2. How did the interview make you feel?/ How are you feeling now?

Appendix F: Summary of attitudes, beliefs and myths of South African male students

Table F1

Summary of attitudes, beliefs and myths about suicidal behaviour of South African male students

Moral acceptability of suicidal behaviour	• People have the right to take their own life. • Suicidal behaviour is an understandable as a way out of difficult circumstances. • Suicide is a rational act, which is preceded by a careful weighing up of costs and benefits. • Suicide is one of the worst things you can do to family and friends. • Suicide is a selfish and inconsiderate act. • Suicide is a crime committed against family and friends. • People who engage in suicidal behaviour hurt family and friends. • People who engage in suicidal behaviour bring shame onto the family • People who engage in suicidal behaviour destroy the family unity. • Suicidal behaviour is not acceptable because it is against God/religion. • Suicide means eternal damnation in hell. • Suicidal behaviour is acceptable if a person does not have strong relational ties to other people. • Suicidal behaviour is acceptable if a person does not believe in a higher deity. • Depression is treatable and therefore is not an understandable reason for people to commit suicide. • Mental illness with psychotic symptomology is an understandable reason for suicidal behaviour, because the affected person may not have acted rationally.
Perceived causes and risk factors of suicidal behaviour	**Social, cultural and economic factors** Suicidal behaviour is caused by: • young people having difficulty to form an identity in South Africa, which still suffers from a fragmented identity seventeen years after apartheid • a breakdown of cultural ties, which deprives young people from an important value base • a culture of violence in South Africa, where there is little regard for human life • a poor education system and lack of opportunity, which leads young people to be disillusioned about their future

Masculinity
Suicidal behaviour is caused by:

- the male stereotype of suppressing instead of expressing emotions
- the tendency of men to engage in behaviours, such as excessive alcohol or drug use, aggression, violence and risk-taking, instead of seeking help for psychological distress
- the stereotypical view that male suicidal behaviour signifies strength and courage, whereas female suicidal behaviour signifies weakness and cowardice
- the stereotypical view that not completing suicide as a man is considered a failure
- men not being able to meet the expectation of being the family breadwinner in times of financial recession and women empowerment
- changes in roles and power dynamics in gender relationships due to the empowerment of women
- the social pressure to be the 'ideal' man for women

Sexuality
Suicidal behaviour is caused by:

- supressing homosexuality in a context in which there little tolerance and openness around sexuality
- an inner conflict about whether or not homosexuality is a religious transgression
- not feeling accepted by others for one's homosexuality

Interpersonal relations
Suicidal behaviour is caused by:

- having no support structures
- childhood neglect
- interpersonal conflict
- physical and emotional abuse
- peer pressure and bullying

Illness
Suicidal behaviour is caused by:

- mental illness, such as depression and bipolar disorder
- having a severe or incurable illness and not wanting to live a life of suffering any longer

Cognitive factors
Suicidal behaviour is caused by:

- a pessimistic view of the future
- perceiving obstacles, such as unemployment, financial difficulties and academic failure, and the subsequent desire to give up and escape these
- a sense of losing control or direction

- a perceived lack of social support
- lack of adaptive coping skills, such as problem-solving and decision-making skills
- a perception of not being accepted by others for being different from them/ low self-esteem
- a narrow focus on only one aspect of life

Emotional state

Suicidal behaviour is caused by:

- intense and overwhelming feeling of anger, depression, hopelessness, helplessness, loneliness and shame
- an inability to regulate one's emotions

Perceived motives for suicidal behaviour

People who engage in suicidal behaviour want to:

- escape feeling trapped/ashamed/ isolated/hurt
- get attention from others
- get sympathy from others
- hurt others
- communicate to others the anger/pain/shame felt inside
- end a perceived meaningless existence
- find out what it means to die (curiosity)
- achieve something other than death

Perceived prevention and protective factors of suicidal behaviour

- Suicidal behaviour can be prevented, since people who engage in suicidal behaviour usually communicate distress or suicidal intent, verbally or behaviourally, beforehand.
- Suicidal behaviour is difficult to be prevented, because it usually happens unexpectedly.
- To prevent suicide it is better not to talk about suicide directly, because this may evoke suicidal thoughts in people.

Prevention strategies

Suicidal behaviour can be prevented by:

- promoting social connectedness
- teaching young people adaptive coping skills
- religious beliefs and religious practices, such as going to church and praying
- building loving and supportive intimate relationships
- addressing masculinity stereotypes that are problematic with regard to suicidal behaviour
- medication and seeking psychotherapeutic help from mental health care professionals
- suicide awareness interventions in schools and availability of school counselling services to learners
- giving young people more information about sexuality and a space to negotiate their sexual identities
- establishing a reason for living and a goal to pursue in life